CHCCCS006
Facilitate individual service planning and delivery

Release 2

Learner guide

aspire
learning resources

CHCCCS006

Facilitate individual service planning and delivery

Release 2

Learner guide

Aspire version 1.3

Aspire
learning resources

Version control and modification history

Version	Release date	Modification
Release 2, version 1.1	April 2017	First release
Release 2, version 1.2	January 2019	Minor corrections as part of our continuous improvement program
Release 2, version 1.3	November 2019	Updated in line with changes to the Home and Community Care (HACC) program.

Aspire is committed to developing quality resources that meet the needs of our customers. However, occasionally Aspire finds, or is notified of, errors. Please refer to our website at www.aspirelr.com.au to see if there are any updates that may be relevant to you.

Every effort has been made to ensure the information in this book is accurate; however, the author and publisher accept no responsibility for any loss, damage or injury arising from such information.

Except where an information source is acknowledged, the names and details of individuals and organisations used in examples are fictitious and have been devised for learning purposes only. Any similarity to actual people or organisations is unintentional.

All websites referred to in this unit were accessed and deemed appropriate at time of publication.

Aspire Training & Consulting apologises unreservedly for any copyright infringement that may have occurred and invites copyright owners to contact Aspire so any violation may be rectified.

Contact details

Participant

Name: ....

Start date: ....

Phone number: ....

Email: ....

Work location

Name: ....

Address: ....

Postal address: ....

Workplace supervisor name: ....

Phone number: ....

Fax: ....

Email: ....

Registered Training Organisation (RTO)

Name: ....

Address: ....

Postal address (if different): ....

Phone number: ....

Fax: ....

RTO contact name: ....

Mobile: ....

Email: ....

Contents

Before you begin

This learner guide is based on the unit of competency *CHCCCS006 Facilitate individual service planning and delivery*, Release 2. Your trainer or training organisation must give you information about this unit of competency as part of your training program. You can access the unit of competency and assessment requirements at: www.training.gov.au.

How to work through this learner guide

This learner guide contains a number of features that will assist you in your learning. Your trainer will advise which parts of the learner guide you need to read, and which practice tasks and learning checkpoints you need to complete. The features of this learner guide are detailed in the following table.

Feature of the learner guide	How you can use each feature
Learning content	▶ Read each topic in this learner guide. If you come across content that is confusing, make a note and discuss it with your trainer. Your trainer is in the best position to offer assistance. It is very important that you take on some of the responsibility for the learning you will undertake.
Examples and case studies	▶ Examples of completed documents that may be used in a workplace are included in this learner guide. You can use these examples as models to help you complete practice tasks and learning checkpoints. ▶ Case studies highlight learning points and provide realistic examples of workplace situations.
Practice tasks	▶ Practice tasks give you the opportunity to put your skills and knowledge into action. Your trainer will tell you which practice tasks to complete.
Video clips	▶ Where QR codes appear, learners can use smartphones and other devices to access video clips relating to the content. For information about how to download a QR reader app or accessing video on your device, please visit our website: www.aspirelr.com.au/help
Summary	▶ Key learning points are provided at the end of each topic.
Learning checkpoints	▶ There is a learning checkpoint at the end of each topic. Your trainer will tell you which learning checkpoints to complete. These checkpoints give you an opportunity to check your progress and apply the skills and knowledge you have learnt.

Foundation skills

As you complete learning using this guide, you will be developing the foundation skills relevant for this unit. Foundation skills are the language, literacy and numeracy (LLN) skills and the employability skills required for participation in modern workplaces and contemporary life.

The following table outlines specific foundation skills noted for your learning in this learner guide.

Foundation skill area	Foundation skill description
Learning	▶ Understanding your job role, organisational procedures and legal responsibilities ▶ Managing your work and seeing how well you are going and making goals for yourself at work ▶ Seeking professional development opportunities for continuous improvement
Reading	▶ Understanding how documents are presented and being able to navigate through documents ▶ Understanding industry- and job-specific terminology ▶ Interpreting key information in relevant documents ▶ Understanding routine workplace checklists and documentation
Writing	▶ Planning, drafting and writing reports and documents ▶ Communicating through written letters, email and online ▶ Recording progress; reporting incidents
Oral communication	▶ Clarifying instructions ▶ Providing information ▶ Supporting others through encouragement, negotiation and conflict resolution ▶ Using body language to model desired behaviour and responding to others' body language
Numeracy	▶ Calculating costs, weights, measurements of height and distance ▶ Interpreting measurements
Teamwork	▶ Working well with other people by cooperating, collaborating, encouraging and building rapport
Planning and organising	▶ Planning your workload and commitments ▶ Implementing tasks ▶ Completing work on time ▶ Knowing how to deal with hazards and risks
Making decisions	▶ Understanding and applying decision-making processes ▶ Reviewing the impact of your decisions
Problem-solving	▶ Identifying problems ▶ Working out how to fix a problem using problem-solving processes and reviewing the outcome
Innovation and creation	▶ Recognising opportunities to develop and apply new ideas ▶ Generating ideas by thinking of new ways to do something ▶ Making suggestions to improve work

Foundation skill area	Foundation skill description
Technology and digital literacy	▶ Efficiently using digitally based technologies and systems correctly and safely ▶ Accessing, organising and presenting information ▶ Using equipment correctly and safely

What do you already know?

Use the following table to identify what you may already know. This may assist you to work out what to focus on in your learning.

Topic	Key outcomes	Rate your confidence in each section
Topic 1 Establish and maintain relationships	1A Conduct interpersonal exchanges in a manner that develops and maintains trust and goodwill	☐ Confident ☐ Basic understanding ☐ Not confident
	1B Maintain confidentiality and privacy of the person	☐ Confident ☐ Basic understanding ☐ Not confident
	1C Recognise and respect diverse and multifaceted needs of the individual and collaborate with others	☐ Confident ☐ Basic understanding ☐ Not confident
	1D Provide accurate information about service delivery and support the interests, rights and decision-making of the person	☐ Confident ☐ Basic understanding ☐ Not confident
Topic 2 Prepare for planning	2A Determine the person's life stage physical and psychological factors that will influence service delivery	☐ Confident ☐ Basic understanding ☐ Not confident
	2B Explain the planning process purpose and discuss different service options with the person	☐ Confident ☐ Basic understanding ☐ Not confident
	2C Work with the person to determine readiness for the development of an individualised plan and select most appropriate service option	☐ Confident ☐ Basic understanding ☐ Not confident

Topic	Key outcomes	Rate your confidence in each section
	2D Determine who needs to be included in the planning process, organise practicalities, and liaise with the assessor of the person's requirements prior to the planning session	☐ Confident ☐ Basic understanding ☐ Not confident
	2E Collate and prepare information and distribute to relevant stakeholders	☐ Confident ☐ Basic understanding ☐ Not confident
Topic 3 Plan service delivery	3A Respect the person's perspective, foster their strengths and capacities, and promote their participation	☐ Confident ☐ Basic understanding ☐ Not confident
	3B Follow process requirements of service planning tools	☐ Confident ☐ Basic understanding ☐ Not confident
	3C Identify and confirm key aspects of individualised service delivery by working collaboratively with the person and other stakeholders	☐ Confident ☐ Basic understanding ☐ Not confident
	3D Consider interrelated needs of the person and plan an integrated approach to service delivery	☐ Confident ☐ Basic understanding ☐ Not confident
	3E Conduct risk assessment specific to the person's circumstances, discuss and work collaboratively with person to minimise risk	☐ Confident ☐ Basic understanding ☐ Not confident
	3F Manage any conflict or differences with regard for the person's perspective	☐ Confident ☐ Basic understanding ☐ Not confident

Topic	Key outcomes	Rate your confidence in each section
Topic 4 Review service delivery implementation	4A Consult with relevant people to assess the quality of, and satisfaction with, service	☐ Confident ☐ Basic understanding ☐ Not confident
	4B Address and report on any problems with the quality of, or satisfaction with, service delivery within organisation procedures	☐ Confident ☐ Basic understanding ☐ Not confident
	4C Work with the person and others, to identify and respond to the need for adjustments to individualised plans and support the person's self-determination	☐ Confident ☐ Basic understanding ☐ Not confident
	4D Identify areas for improvement to overall service delivery implementation of organisation	☐ Confident ☐ Basic understanding ☐ Not confident
Topic 5 Complete reporting requirements	5A Clearly record planning activities and decisions made, and prepare reports and other documentation correctly	☐ Confident ☐ Basic understanding ☐ Not confident
	5B Maintain currency of documentation by making appropriate updates	☐ Confident ☐ Basic understanding ☐ Not confident
	5C Incorporate review findings into continuous improvement processes	☐ Confident ☐ Basic understanding ☐ Not confident

Topic 1

In this topic you will learn how to:

1A **Conduct interpersonal exchanges in a manner that develops and maintains trust and goodwill**

1B **Maintain confidentiality and privacy of the person**

1C **Recognise and respect diverse and multifaceted needs of the individual and collaborate with others**

1D **Provide accurate information about service delivery and support the interests, rights and decision-making of the person**

Establish and maintain relationships

Developing individual plans should always be collaboration between the care provider (the coordinator) and the care receiver (the client). Collaborations are only successful if the coordinator and the person receiving support share mutual respect and positive regard. As a coordinator, you must take a leadership role, making sure you establish and maintain appropriate working relationships with clients, and others involved in their health care. It is crucial you respect individual differences.

1A Conduct interpersonal exchanges in a manner that develops and maintains trust and goodwill

People working in aged care, disability, mental health and other community services settings have a high level of responsibility. They are often working with people who are highly vulnerable and who may rely on others for things we take for granted. Sometimes people put up barriers to reduce their vulnerability. Your job is to overcome these barriers, and to make sure you can gather the information you need from the person to develop a plan that maximises their physical and mental health.

Role of the support worker

Workers in community services are often in demanding and busy roles. It can be easy to overlook or neglect important trust and relationship building activities, such as appropriate introductions. Some workers feel that practical tasks, such as providing personal care and assisting in daily living activities, are more important than communication in their roles. Workers need to understand that effective communication is essential for working collaboratively with the person requiring support and the significant people in their lives. Often the person's needs may be complex, or they may have multiple needs. Having a positive working relationship and the ability to communicate clearly will assist in working with the person to meet these needs.

Some suggestions for support workers in their roles are outlined below.

Suggestions for support workers

Clear and appropriate communication will ensure that work with the person is collaborative and effective. It will help the worker avoid misunderstandings.

Good introductions are important to develop positive working relationships, and to ensure the person understands the role of yourself and your organisation.

Practise introductions and other communication skills with your colleagues, or ask your supervisor for support.

Reflect on your initial communication with the people you work with to ensure it is appropriate and effective. Ask for feedback where appropriate.

Interpersonal exchanges

Interpersonal communication is usually seen as communication between two or more individuals, typically in a face-to-face setting. Your interpersonal communication style is impacted by your personality, values and work and personal environments. The style you use can contribute to positive interpersonal exchanges, or could hinder developing working relationships. Your interpersonal communication style can be considered passive, aggressive or assertive. These three interpersonal communication styles are described below.

Passive

A passive interpersonal communication style is when a person does not express their thoughts or feelings or asks for what they need. The person can feel 'walked over' and may bottle up their feelings and become resentful. This may be when a worker does not talk to their supervisor about their need for a different shift, or about an issue they are having trouble with. It may also be when they accept inappropriate or abusive language from the person they are delivering services to.

Aggressive

An aggressive interpersonal communication style is when a person expresses themselves in a hostile or forceful way. Both their verbal and non-verbal language may be unfriendly or hostile. For example, the person may blame their supervisor or the organisation for services not being delivered appropriately; or they may label a co-worker or person receiving services as 'lazy' or 'stupid'.

Assertive

Someone with an assertive interpersonal communication style will clearly express what they think, how they feel and what they want, while still considering the other person's perspective. This style increases your likelihood of getting your needs met and maintaining good relationships. So a worker may ask their supervisor for a day off when they are feeling stressed, or it is their child's sports day; or a worker may be able to clearly explain to a person receiving services why they cannot meet with them during their holidays.

Develop and maintain trust

If the person you are working with does not trust you, they may not be open with you. They may share only a selected amount of information about their wants, needs, preferences, barriers, goals, medical history and health condition. As a result, the plan you develop may not address their needs or, in worst case scenarios, may actually cause them harm. You must also consider that if a person has had negative experiences with any other professionals, they may find it harder to trust you. Developing trust involves using a number of strategies, some of which are discussed here.

Demonstrating professionalism

▶ Make sure you look the part – if your clothes are untidy or dirty, it is possible people will see you as being untrustworthy. A clean and tidy appearance suggests that you care about your job and, as an extension of this, the person and their needs.

▶ Maintain and develop your skills and expertise, so you can respond appropriately to people.

▶ Be competent – perform all duties to the required standard. It can be worthwhile seeking feedback from your manager and others to check you are meeting standards.

▶ Follow up on all promises – don't make promises you are unable to keep or that fall outside of your scope of practice or level of responsibility.

Demonstrating respect

▶ Have a positive regard for the person – your actions reflect your feelings. If you have a genuine interest in the person's wellbeing, it is reflected in your actions.

▶ Have empathy – imagine how you would feel if you were in the person's position.

▶ Be open – understand that the person's point of view might be different from yours.

▶ Do not just tell the person you are interested in helping them, show them by allowing the time needed to discuss their concerns, preferences, wishes, needs and goals. Attend to what they are saying.

Using active listening

▶ Use active listening to show the person you are interested in what they have to say.

▶ Briefly recap what the person has said in your own words.

▶ Soften your summary with phrases like:
  – 'You feel …'
  – 'It sounds like you …'
  – 'You think …'

▶ Use paraphrasing statements more than questions.

▶ Allow plenty of time and pauses for the speaker to add to what they are saying.

▶ Focus on the last or the most prominent feeling, if more than one feeling is expressed.

▶ Do not add to or subtract from what the speaker has said.

▶ Use neutral words, body language and tone of voice.

Develop and maintain goodwill

Goodwill is often about an emotional bond with the people that you work with. It is a feeling of appreciation on their part, developed by providing good services and communicating respectfully. Often goodwill is developed by 'going the extra mile'. This could perhaps be spending a little extra time actively listening to a person, or supporting them to access services rather than just making a referral.

By developing and maintaining goodwill, you will increase trust and create opportunities to work effectively towards goals. Developing goodwill is essential to establishing and maintaining positive long-term working relationships.

Example

Conduct interpersonal exchanges in a manner that develops trust and goodwill

Fatima is a case manager at an employment services provider. She meets with Nadine who requires support services. They have the following conversation:

Fatima: Hi Nadine. Thank you for meeting with me today.

Nadine: I don't know why I'm here. It's not like you'll get me a job.

Fatima: You're right. I can't get a job for you. I can help you find yourself a job, if you let me help you.

Nadine: You're the fifth case manager I've had. I'm sick of this.

Fatima: I can appreciate how upsetting this is. It would help me if I knew what sort of job you would like.

Nadine: That's the problem. I'm 35 and I don't know what I want to do.

Fatima: Many people don't find their ideal job until they are older than you. Some people find doing a career preference quiz helpful. Is that something you would like to do?

Nadine: Yes – can we do it now?

Fatima: We're running a little short of time today. I'm scheduled to meet with you in a month, but it would be helpful if I had the results of the test before then. If you would like, I can book an appointment with another consultant, Mandy.

Nadine: Great – you're passing me on to someone else and I'll have to start again.

Fatima: No. I will speak with Mandy to make sure she has a test ready when you arrive. Mandy will upload the information onto the system so I can access it before our next meeting.

Fatima uses active listening to find out about and acknowledge Nadine's concerns. Fatima is honest about her limitations, which increases Nadine's confidence. Fatima's persistence demonstrates a genuine interest in Nadine's needs. Fatima has built a foundation for later interactions. Fatima must make sure she follows up with Mandy and fulfils her promises to Nadine.

Practice task 1

1. Name three ways to develop trust and give one example of how to demonstrate each.

....

....

....

....

....

....

....

....

....

....

....

....

2. Explain what an assertive interpersonal communication style is and two benefits of this style.

....

....

....

....

Click to complete Practice task 1

1B Maintain confidentiality and privacy of the person

When you work in community services, you encounter people who can be vulnerable and reliant on care workers for all their needs. Workers may be involved in what are, for most people, intimate activities such as showering, dressing, grooming and toileting, or discussing personal issues and concerns. You and others may also be aware of information about the person that is personal and could even be embarrassing to them. It is your responsibility to make sure you maintain the privacy and confidentiality of the person, as outlined in the *Privacy Act 1988* (Cth) and your organisation's policies and procedures.

Privacy, confidentiality and disclosure

Maintaining the privacy and confidentiality of the people receiving services from your organisation is essential. When discussing a person's situation, always be aware of maintaining their privacy and protecting confidential details. You always need the person's consent if you wish to talk about their situation. Often people are happy to give their consent because they know you want to help.

Maintaining confidentiality is part of respecting a person's privacy and individual rights. In practice, confidentiality means not discussing an individual's personal information unless they have given their consent for this to happen. There are exceptional circumstances that do enable you to disclose private information but this is generally only when you become aware that someone may harm themselves or someone else.

You can read more about privacy, confidentiality and disclosure at the following sites:

▶ http://aspirelr.link/aacqa-privacy-policy
▶ http://aspirelr.link/law-handbook-privacy-confidentiality

Legal aspects of privacy and confidentiality

Privacy refers to the client's right and ability to limit the amount of people who access their personal space and possessions. Confidentiality refers to an organisation's responsibility to take all due care when collecting, using, storing and accessing a person's personal information. A person has a right to privacy when receiving personal care, and the right to control who has access to their personal information. There are many reasons why it is important to maintain a person's privacy and confidentiality. Some of these reasons are explored below.

Under federal and some state and territory-based laws, there are strict provisions dictating that:

▶ information can only be gathered if it is needed to provide a service
▶ clients have a right to determine the information they share and how the information is used
▶ information should be stored securely
▶ information should not be shared without the client's informed consent.

There are a number of regulations and standards in the aged care sector and the disability services sector that explain the responsibilities of providers, as well as the rights of clients. These responsibilities include maintaining clients' dignity.

Your organisation should have set policies and procedures designed to promote client dignity and wellbeing.

Follow organisational policies and protocols

The first thing you must do is to make sure you understand the policies and protocols in your workplace that relate to privacy and confidentiality. Once you have a clear understanding of the expectations of your workplace, you need to implement these protocols in your everyday work. Relevant policies and procedures that your organisation will have are listed below.

Policies and procedures include instructions about:

▶ the organisation's privacy policies and procedures to the client

▶ the organisation's confidentiality policies and procedures to the client

▶ who can access client information

▶ how client information can be used

▶ where client information must be stored

▶ how to store information securely.

Example

Maintain confidentiality and privacy within organisation policy and protocols

Susie has just started a new job in a community services organisation. As part of her induction, Susie reads through some of the organisation's policies and procedures relevant to confidentiality and privacy.

Susie meets with Luke and explains his rights regarding privacy and confidentiality. After they have talked, Susie becomes aware that Luke might benefit from engaging with another organisation. Susie discusses this with Luke, and asks his permission to contact the organisation. When Luke agrees, Susie asks him to sign a disclosure agreement. She explains that the agreement outlines who she will share information with and what information will be shared.

Practice task 2

Read the case study, then complete the task that follows.

Case study

Ruth meets with Sherie on Friday afternoon and the meeting runs longer than she expected. As Ruth has plans for the evening, she leaves the notes she took during her meeting with Sherie on her desk and locks the door as she leaves. Over the weekend the cleaners access her office to clean it.

---

1. What organisational policies and procedures might be relevant in this situation?

2. On Monday morning, Ruth calls a contact at another organisation to discuss Sherie's situation, as she feels this organisation can meet some of Sherie's needs. Explain what Ruth should have done prior to making this phone call.

Click to complete Practice task 2

1C Recognise and respect diverse and multifaceted needs of the individual and collaborate with others

Often people accessing community services are facing complex situations. People accessing an organisation will come from a variety of backgrounds and will accordingly have diverse needs. These needs may relate to their personalities, their cultural backgrounds, their life experiences and the skills or level of support they have within their families and the community. For example, two people with the same mental health diagnosis may access the same organisation. One person may require support to access accommodation and health care. The other person may require support to return to education or employment. Individual needs are rarely simple, and often have many different aspects or sides to them.

These diverse and multifaceted needs may require you to collaborate with other service providers to ensure the person's needs are met.

Diverse needs of individuals

People requiring support from community service organisations are as diverse as the general population is. They come from different cultural and socioeconomic backgrounds, are different ages and genders, and have varying levels of support from their families, friends and the wider community. This means that the needs of these individuals are also diverse.

You will need to acknowledge and understand the diverse needs of the people you support, and respect the varying backgrounds that underlie these needs. You will also need a range of strategies to identify and meet the needs of individuals, which could include some of the ideas below.

Strategies to support diverse individuals

▶ Use interpreters

▶ Use translated materials

▶ Use pictures and photographs

▶ Be aware of your own biases and prejudices

▶ Recognise diverse needs and individual abilities and language

▶ Treat people fairly and acknowledge differences

▶ Respect differences

▶ Use appropriate verbal and non-verbal communication

Communicate with people from diverse backgrounds

The diverse backgrounds of people you support may require the use of a different communication strategies and considerations. For example, cultural differences might mean there are different languages or ways of behaving that affect communication. You may need to address a person in a particular way. It is important to know how to change your communication to suit the culture of the people you are working with. You may need to engage the services of a cultural or language interpreter. You can get this background information from the care plan, or you may like to do some research at your local library or on the internet about the cultural practices of different ethnic groups. Your organisation may organise specific training regarding cultural diversity. Many cities and large towns have multicultural associations who are often willing to share information about their culture to create awareness.

Respect cultural practices

As we have discussed, language and culture affect the way people behave. Some cultures have expectations about eye contact, gestures and how you communicate with someone who is older than you, which may be different to the cultural expectations you are used to. For example, in some Asian cultures it is considered rude to look into someone's eyes when talking to them, whereas in many western cultures, maintaining eye contact is a sign of respect. If you were caring for older people from an Asian cultural background, or from an Aboriginal and/or Torres Strait Islander background, you would need to remember to avoid constant eye contact when speaking with them. If you are unsure, remember most people are happy to answer polite questions regarding their culture.

Some more guidelines relating to gestures are discussed below.

Different meanings of gestures
▶ In Western cultures, people may beckon with their index finger to indicate 'Come here'. However, in the Middle East, Portugal, Spain, South America, Japan, Indonesia and Hong Kong, it is rude to beckon with your index finger.
▶ It is rude to use the index finger to point in the Middle and Far East. However, pointing in a direction or at an object is common in western cultures.
▶ In Brazil and Germany, forming a circle with fingers to indicate 'okay' is considered obscene. In Japan, a circle with fingers means money. In France, this gesture can mean 'zero' or 'worthless'.
▶ In some parts of Europe, waving the hand can mean 'No'.
▶ In Nigeria, it is very rude to wave too close to another person's face.
▶ Nodding the head up and down to say 'Yes' is used in western cultures. However, in India, Bulgaria and Greece, nodding the head means 'No'.

Multifaceted needs of individuals

It is rare for an individual to have only one simple need when accessing support. The reality is that most people experience complex and multifaceted needs. We know, for example, that people experiencing homelessness often also have dental, health and mental health needs that also need to be addressed. Older people may have

mobility or health issues that exist side by side with grief and loss issues, nutritional concerns, or mental health issues. A person with an intellectual disability may require employment support, as well as support to address relationships, sexuality, accommodation, or other issues.

You can demonstrate respect for the individual and provide good support by understanding the multifaceted needs of the person. Some ideas of how to work with people with multifaceted needs are below.

How to work with people with multifaceted needs

▶ Support the person to identify their needs.

▶ Understand the impact of multifaceted needs on the individual and their ability to manage daily living tasks and reach goals.

▶ Support the person to prioritise their needs and goals.

▶ Be prepared to use a variety of strategies to meet needs.

▶ Work collaboratively with the person and other service providers to ensure all needs are met.

Collaborate with other service providers

Individuals with complex, multifaceted needs will require a range of services to meet their needs. While some large community services organisations may have the resources and programs to meet all these needs, the likelihood is that you will need to collaborate with other service providers to gain specialist support for the people you provide services for. Other service providers can also assist you to understand the experiences of individuals and to gain new knowledge and skills. For example, an organisation that works with refugees may be able to support the person you are working with regarding issues around trauma, but may also support you to understand the refugee experience.

Below are some examples of when collaborating with other service providers might be beneficial.

Mental health services

Provide mental health care for people who are:

▶ experiencing stress due to other issues

▶ experiencing symptoms while managing other needs (like homelessness, grief, unemployment, illness, aging).

Disability services

Provide additional assistance to individuals with disabilities who are accessing employment, health or accommodation services.

Employment services

Provide specialist employment support to individuals with disabilities, mental health issues, refugees and migrants, or young people.

Health services

Provide health and dental care for individuals experiencing homelessness, disability, mental health concerns, alcohol and other drug use.

Accommodation services

Provide independent or supported accommodation options to individuals experiencing, or at risk of, homelessness due to other issues (like disabilities, mental health concerns, abuse or neglect, ageing).

Translators/interpreters

Provide resources and language services to individuals who do not speak English as a first language or for Aboriginal or culturally diverse people.

Example

Recognise and respect diverse and multifaceted needs of the individual and collaborate with others

Lisa works at a residential aged care facility. Mrs Jonas has recently moved into a room after a series of falls at home. Lisa notices that Mrs Jonas is very withdrawn and constantly refuses invitations from staff and other residents to socialise or participate in activities. Mrs Jonas tells Lisa she does not like using a wheelchair.

Lisa sits down with Mrs Jonas to talk about her mobility issues. Lisa and Mrs Jonas work on a care plan to increase her ability to move around her new environment more easily, including using different walking aids so she does not have to use the wheelchair. During this conversation, Lisa becomes aware that Mrs Jonas is not avoiding social activities just because of her mobility issues. Mrs Jonas expresses her grief at having to move out of her home of 35 years and her beautiful garden. She is also embarrassed that she has put on weight since her last fall and no longer fits into her clothes properly.

Lisa supports Mrs Jonas to join the facility's gardening club and to access the community garden where she can again grow flowers and herbs. Lisa then introduces Mrs Jonas to the facility's nutritionist and together they work on a plan to help Mrs Jonas feel more healthy and perhaps lose some weight. Lisa realises that she does not have the capacity to assist with Mrs Jonas' feelings of grief and loss, and with permission refers Mrs Jonas to a psychologist to work through her experiences.

Practice task 3

1. Give two examples of a person with multifaceted needs.

2. Give one reason why you may need to collaborate with other service providers to meet needs.

Click to complete Practice task 3

1D Provide accurate information about service delivery and support the interests, rights and decision-making of the person

Most people pursue careers in community services because they have a genuine interest in helping others. Despite this, some workers can impact negatively on a person by developing goals and strategies on behalf of the person, rather than in conjunction with them. This can make a person feel as if their opinion is worthless and their wants and needs unimportant. People who feel like they have control over their own lives (self-determination) are more likely to experience positive mental health than those who feel that they have little power in making decisions or doing what they enjoy. For this reason, it is important to support a person's interests, rights and decision-making. One way to support self-determination for a person is to provide them with clear, accurate and current information about the services your organisation provides.

Information about service delivery

In order to work collaboratively with a person, and to ensure that they are able to make the best choices for themselves and their care, it is important to provide them with clear, accurate information. The person needs information on the types of services provided that they are eligible for, how much these services will cost, where the services will be provided (in their home, at the organisation's office, or elsewhere), how many hours of service they can receive and the time frame for the service, and who will provide the service.

If the person requiring support either does not receive this information or does not understand the information there are consequences for them. They may feel unheard or disempowered, refuse services they need, or may accept services they do not want. They may become frustrated or angry because the services they receive are not what they expected or wanted. For this reason information must be presented in clear language (with the use of translators if required), and must be accurate and current.

Support the person's interests

An individual plan should be person-driven. This means the person should determine the goals and the activities contained in the plan. In some cases workers may feel they have greater insight into a person's needs than the person themselves. However, it is important to discuss this with the person and ensure the final plan reflects the person's own interests, goals and preferences. A person is more likely to meet their responsibilities, as listed in the individual plan, if they have been involved in determining what their responsibilities are.

Here are some tips you can use to help workers gain an understanding of the clients' interests and strengths:

▶ Ask the person about their interests. Sometimes it may be useful to ask about interests at a time before the current circumstances; for example, before the accident, before you became unwell, when you were young.

▶ Support the person to identify previous successes.

▶ Create a trusting working relationship and value the person and their experiences.

▶ Support the person to identify the resources they have available; for example, family, friends, a social group or a doctor.

▶ Get permission to talk to significant others who may be able to assist with identifying strengths.

Support the person's rights

Your role as a worker is to uphold the rights of the people you work with. This means it is important for you to understand the person's rights, such as their right to privacy, basic human rights, or their right to make decisions for themselves. You can support the rights of the individual's you work with by assisting them to identify their rights and make decisions regarding their needs and service requirements. Some rights are encapsulated in law, such as legislation regarding child or elder abuse, or privacy, or anti-discrimination. Other rights are outlined in international treaties or conventions like the International Rights of the Child or the Universal Declaration of Human Rights.

You can read more about human rights at the following sites:

▶ http://aspirelr.link/universal-declaration-human-rights-pdf

▶ http://aspirelr.link/unhr-what-are-human-rights

Support the decision-making of the person

People who are involved and feel some control in the decision-making process have the best outcomes. You can support the person in their decision-making capacity by doing some of the following things.

Provide information

▶ The person can make decisions that are in their best interests by having accurate, current and relevant information. You can support the person by ensuring they have the information they need regarding their identified needs and relevant service provision.

Explore options

▶ Once the person has relevant information, you can support them to explore their options regarding types of service provision. You may assist the person to think in terms of location, time frame, fees, support workers and priorities.

Implications

▶ It is important for the person being supported to understand the implications of their decisions. For example they may only be able to afford limited services and so must prioritise; or they may have difficulty with transport so may need to choose a service that comes to their home.

Support network

▶ If the person has a support network which could include friends, family, community groups, clergy or neighbours, you can support the person to engage them in the decision-making process. Most people find a second opinion useful when making decisions, and family or others who know the person best can support them to make positive decisions.

<div style="border-left: solid;">

Example

Provide clear and current information about service delivery, and support the interests, rights and decision-making of the person

Lucy has recently returned home after a serious car accident that has left her with permanent mobility issues. Rod meets with Lucy to discuss her needs. Lucy and Rod identify that Lucy needs support to maintain her home and garden, transportation to her physiotherapy sessions and some personal care support.

Rod provides Lucy with written information on several organisations and checks online to ensure that the information is current and accurate. He then goes through the information with her to ensure she understands the services provided and the implications of her decisions.

Rod explains the various transport options including taxis which have a cost, and a free transport service from a disability organisation that only runs three days a week. He also explains the services that can be provided by Home and Community Care services, as well as a community volunteer organisation that can assist with gardening.

Rod checks to ensure Lucy understands her options and leaves Lucy to discuss her decision with her mother who lives nearby.

</div>

Practice task 4

1. Describe two ways you can support a person in their decision-making capacity.

2. Explain what might happen if a person requiring support does not understand the information they are given.

<div style="background:#F5A623;color:#fff;font-weight:bold;">Click to complete Practice task 4</div>

Summary

1. Good interpersonal communication is important in establishing trust and positive working relationships.

2. Maintaining privacy and confidentiality in line with legislation and organisational policies is essential.

3. People in need of services come from diverse backgrounds and have complex, multifaceted needs that may require collaboration with other service providers to meet.

4. People receiving support need clear and current information to support them to make good decisions regarding service provision.

Learning checkpoint 1
Establish and maintain relationships

This learning checkpoint allows you to review your skills and knowledge in establishing and maintaining relationships.

Part A

1. Explain what goodwill is and provide one reason why developing and maintaining it is important.

2. Give two examples of when collaborating with other service providers can assist to address diverse and multifaceted needs of individuals.

3. How can you demonstrate respect for the individual, and provide good support services by understanding the multifaceted needs of the person?

Part B

Read the case study, then answer the questions that follow.

> ### Case study
>
> Jo has just started working with Carrie and thinks it would be helpful to look at Carrie's records from the previous organisation she received services from.

1. What are Jo's responsibilities in this situation?

2. What rights should Jo explain to Carrie before asking for the records?

3. Jo realises Carrie does not know much about her organisation or the services provided. Give two reasons why having clear and current information about service delivery is important.

Topic 2

In this topic you will learn how to:

2A Determine the person's life stage physical and psychological factors that will influence service delivery

2B Explain the planning process purpose and discuss different service options with the person

2C Work with the person to determine readiness for the development of an individualised plan and select most appropriate service option

2D Determine who needs to be included in the planning process, organise practicalities, and liaise with the assessor of the person's requirements prior to the planning session

2E Collate and prepare information and distribute to relevant stakeholders

Prepare for planning

A vital part of the service delivery process is planning. In order for the planning process to progress smoothly and to be as effective as possible, it is important for the worker to thoroughly prepare for it. This will mean taking into consideration the person in need of services and their life stage and needs. You will also need to work with the person to explain the purpose of planning, what options they have and which might be most appropriate. You will need to find out who else needs to be involved in the process, who the person wants involved, and ensure that all stakeholders have the information they need and that the practicalities of the process are organised.

2A Determine the person's life stage physical and psychological factors that will influence service delivery

When you begin to organise the planning process, an important starting point is to consider the person requiring services' life stage. You will need to consider the physical and psychological factors that are likely to impact on service delivery. As a person moves from childhood into adolescence, adulthood and finally older adulthood, many factors change in their lives and this needs to be considered in the planning process. It should also be remembered that some life events like a disability, illness or mental health issue can impact on the person's development.

Life stages

Human development follows particular pathways from birth to death. These ages and stages vary from person to person, however many are marked by milestones allowing each stage to be recognised and identified. These milestones make it easy for you to keep track of progress and take action when needed.

Where a person is at in terms of their development influences the types of services they may require and how services are provided. For example, if an infant requires medical treatment, the adults around them will make all decisions. If, however, an adult requires medical treatment there would be an expectation that the options would be discussed with them and that they would, where able, make decisions regarding their own care.

You will need to consider the person's life stage when planning for services as their life stage will influence what significant others are present in their lives, how long services may be required for and what other roles need to be considered, such as job roles or parenting or education.

Stages of development

There are various theories on the stages of development. It is worthwhile you taking the time to research some of these to support your learning.

Erik Erikson (1959) identified eight stages of development, discussed below. This theory is useful in giving you a basis for understanding the various life stages.

Erikson's human development theory

1   **Infancy**
From birth to 12 or 18 months of age – this stage focuses on developing trust (or mistrust) depending on how well a child is nurtured.

2 **Early childhood**
18 months to three years of age – which Erikson refers to as autonomy versus shame. It is a stage where the child develops self-esteem and autonomy.

3 **Childhood**
The pre-schooler stage from three to six years is centred on the theory of initiative versus guilt. During this stage, we tend to mimic adults and start to use imagination or creativity.

4 **Middle childhood**
Six to 12 years. Erikson refers to this stage as industry versus inferiority, as the child must learn to deal with demands to learn new skills.

5 **Adolescence**
This stage covers ages 12 through to 18. If you remember back to your own adolescence, this stage is around identity versus role confusion. This stage depends on what the person actually does to discover their own identity and their relationship with peers.

6 **Young adulthood**
Ages from 18 to 35 and focuses on intimacy and solidarity versus isolation. This is when most of us seek love and companionship. Generally people tend to settle down, raise a family and develop significant relationships.

7 **Middle adulthood**
35 to 55 or 65 is when we are focused on career and work. It is a time in life when we either take on greater responsibilities or develop fears because of inactivity. This is a stage where major life changes occur.

8 **Late adulthood**
Aged 55 or 65 to death. Erikson refers to this stage as integrity versus despair. It is viewed as a stage of wisdom. People will either experience a sense of achievement in their life or view their life as missed opportunities.

Physical factors

As we move through life stages from birth to death, there are physical factors that impact on what we might need. You will need to recognise what physical factors are present in the life stage of the person, but remember that each person is an individual and may not have the same factors impacting as someone else the same age. Some examples of physical factors are below.

Physical factors
Adolescence Factors could include significant growth, injuries related to risk taking behaviour and puberty.
Middle adulthood Factors could include some hearing loss or deteriorating eye sight, weight gain and menopause for women.
Late adulthood Factors could include mobility issues, an increase in health concerns and vulnerability to illness, increase in chronic issues like arthritis and dental health concerns.

Psychological factors

Life stage psychological factors can have a significant influence on service delivery. The person's perspective on their life and events in it can be impacted by their psychological development and maturity. For example, an adolescent who is at a stage where they are self-aware and easily embarrassed may be focused on privacy, and uncomfortable with any service delivery that 'invades' this privacy. An elderly person who has experienced significant loss, may not be able to fully participate in services due to grief.

Example

Determine the physical and psychological factors relevant to the person's life stage that will influence service delivery

Bob is 52 years old and has been unwell in a psychiatric ward for almost five months. Before he became unwell, Bob had a managerial position with a major bank and lived at home with his partner and their two children. Since his illness, Bob has been made redundant from his position.

Bob feels like the most important thing for a man his age is to provide for his family. Bob's sense of self and confidence came from being successful in business. While Bob recognises that there are other aspects of his life that he needs support in, his focus is on returning to the workforce.

v1763

When planning for service delivery with Bob, the support worker will need to consider that at Bob's life stage employment is an important role and will need to considered with service delivery.

Practice task 5

Read the case study, then complete the task that follows.

Case study

Frederick is 76 years old and you have recently been asked to prepare an individualised plan with him. Frederick lives in his own home, but recently, after some significant complications due to diabetes, he has had to move to supported accommodation. Since the complications, Frederick uses a wheelchair and is no longer able to play golf, which he has done for many years.

1. What are the physical factors of Frederick's life stage that may influence service delivery?

2. What are two psychological factors of Frederick's life stage that may influence service delivery?

Click to complete Practice task 5

2B Explain the planning process purpose and discuss different service options with the person

Individual plans are documents that outline the type of services that are to be provided. They should be used as tools to help achieve outcomes. An effective plan is one that is referred to and followed by all stakeholders. Thorough planning can help ensure the effectiveness of the planning process. Stakeholders, including the person receiving services, their significant others, family, workers and other health care professionals, are more likely to support the planning process if they understand the purpose of this process. It is therefore essential that you explain why a care plan is important and what it contains to all stakeholders.

Develop individual plans

During the planning process, you should establish the person's goals, determine the person's current status and develop a strategy to bridge the gap between the person's actual status and their desired status. Further details about each of these steps is provided below.

Establish person's goals

▶ Review the person's file. Case notes, letters from other health professionals and the results of assessment can provide you with valuable information about what a person hopes to achieve.

▶ Ask the person what their goals are. The person in need of services is the best source of information about what is important to them.

Determine person's status

▶ The person's file can yield valuable information about their current status. It can tell you whether their condition is improving, getting worse or remaining stable. It can also help you understand what a person's strengths are and identify any areas of concern.

▶ You must make sure you check the currency of information in the person's file. If the file has not been updated, it is possible that the information no longer provides a true picture of the person's current health status. Ask the person, or with permission, family members and others, for current details if you are unsure.

Develop a strategy

▶ You will need to develop a strategy to bridge the gap between the person's current status, and desired status. Ask the person what activities they prefer, what is comfortable for them and their likes and dislikes. The strategies selected should be realistic and take into account limitations such as finances, your organisation's policies and procedures, and the person's capability. You must make sure that all required resources are available.

Explain the purpose of the planning process

The community services sector, including aged care, disability, mental health and more, are all regulated. This means that documentation is necessary to make sure all actions can be tracked, monitored and reviewed, as required. A person may find the whole process overwhelming. They may not understand why you need to ask them so many questions, or why you write down their answers. They may also be unaware of the level of planning required when developing the individualised care plan and related documentation.

The person may feel disempowered by the process and become uncooperative in an attempt to regain control. They are more likely to cooperate with you, other coordinators and workers if they understand how the process can help them achieve their goals. This empowers them with a sense of control that is important for all people.

Discuss different service options

You will need to discuss the different service options available to the person. It is important that you are aware of the service options available at your organisation and that you are able to clearly outline these to the person. Remember to check that they understand each of the options available and the costs and benefits of each. Below is an example of some service options, and the features of each.

Service options

Attendant care and support work services

Attendant care services help the person do everyday tasks like personal care, domestic tasks, home nursing, community engagement and implementing rehabilitation plans.

Recreation, leisure, community access

Recreation, leisure and community access services support the person to access and participate in recreation and leisure activities like sport, art, music or community groups.

Community nursing services

Provide professional nursing services to the person in their own homes.

Complex support coordination

Supports the person to manage a range of cross-sectoral services to ensure their needs and goals are met. Complex support coordination is often in the form of case management.

Positive behaviour support services

Provide support for challenging behaviours using a specific positive reinforcement strategy.

Respite services and short-term stays

Supports the person and their caregivers by providing a variety of options for respite. Includes carers coming into the person's home to provide respite, or the person going to another location for a period of time.

Emergency support

A variety of supports are available when a physical or psychological emergency occurs. These range from ambulance or transport services, to telephone or online helplines and visiting emergency experts.

Brokerage services

Brokerage services facilitate the provision of needed services by 'purchasing' these services on behalf on the person in need of service provision.

Healthcare planning

A service to plan and implement health care, as needed.

Supported accommodation services

Provides accommodation staffed by professionals who can support the person with identified needs. Support can differ dependent on the person's needs and goals.

Example

Explain the purpose of the planning process and discuss different service options with the person

Tanya O'Loughlin, a teacher with qualifications in disability services, says: 'I sometimes illustrate the process for a person. I take a sheet of paper. On one side I draw a circle with the caption, "You are here". I then get them to brainstorm their strengths and weaknesses. Then I draw a circle on the other side of the page with the caption, "Destination". I then get them to brainstorm where they would like to be. Finally I ask the question, "How will we get from where you are to where you would like to be?" This visual helps a person better understand the planning process by making the steps far more concrete.'

Practice task 6

1. What are the three steps to developing an individualised plan?

   ....

   ....

2. Describe why it is important to explain the purpose of the planning process to a person.

   ....

   ....

Click to complete Practice task 6

2C Work with the person to determine readiness for the development of an individualised plan and select most appropriate service option

Mental health, aged care, home and community care and disability services standards make it clear that organisations and workers must take all reasonable steps to make sure the person in need of services is the driver of the care plan. After all, it is the person whose quality of life is affected by the quality of the care plan. Three main factors that impact the person's readiness to plan are:

▶ their ability to understand the purpose of the care plan and make informed decisions

▶ their ability to carry out their responsibilities

▶ their attitudes about individualised plans and the people and organisations involved in providing care.

Individualised planning

Individualised planning is a person-centred process that records the goals and aspirations of the person, as well as strategies to achieve them. The plan should also document what they would like their life to be like now and into the future. Individualised plans mean that the person directs the process and makes their own choices about service provision and their lives more generally. It explores the person's needs, aspirations for their own life and their goals and documents how these will be achieved. It also identifies the supports needed, and whether these are available and flexible.

Work with the person

As a worker, you will need to adjust the way you work to meet the diverse needs and abilities of the individuals you provide services for. Individualised planning and person-centred approaches encourage the worker to be 'with' the person and to develop a plan alongside them. Depending on your role, and the services provided by your organisation, you may be working with people in supported accommodation or residential care, with people living in the community, with young people at school or with people in hospital.

Below are some of the strategies you may use when working with a person.

You may work with a person:

▶ using open and closed questions

▶ using formal assessment tools

▶ by demonstrating skills to them

▶ by providing personal care to them

▶ by supporting them to access social, recreational or other activities.

Determine readiness

Individualised plans can relate to all aspects of life, from the basics, such as meeting nutritional and accommodation needs, to more complex activities, such as making friends, building self-esteem and fulfilling one's potential. People's abilities and their life experiences can impact their ability to plan. You need to be able to work through all the factors that impact a person's ability to plan to determine whether they are ready to help with preparing their plan. These factors are explained here.

Capacity to decide

▶ A range of factors can limit a person's decision-making ability. Cognitive impairment, intellectual disability, brain injury, depression and substance misuse problems can prevent a person from making decisions that best meet their needs. These factors also act as a barrier to informed consent.

Capacity to understand the process

▶ People who do not speak English, have language disorders, have acquired brain injury or intellectual disabilities may not be able to understand simple or complex verbal or written information. Capacity to understand the process varies greatly between individuals. You need to make sure they understand what you are telling them and not just nodding in agreement. You may need to use the services of an interpreter or an advocate so you can be sure the process is completely understood and the person knows what is expected of them.

Capacity to participate

▶ A person's capacity to participate can also be affected by their confidence, sense of self-worth and the difference in power between you as a professional, and the person as a consumer of the services. This power imbalance may be amplified by a variety of factors, such as gender or culture. People from disadvantaged groups may be less likely to feel confident about providing input.

Involvement of an advocate

▶ An advocate is an individual who promotes and ensures the person's full and equal enjoyment of all human rights, as well as the ability to participate in the community. An advocate can assist the person to understand their rights and the choices that are available to them.

Select most appropriate service option

As part of the process of delivering person-centred care, you must make sure you choose the planning options that best meet the person's needs. Discussing different planning options with the person will have presented them with options, and the advantages and disadvantages of each approach. Each person is an individual with their own likes, dislikes, experiences and background, so what works for one person may not work for another. Some people prefer a more conversational approach to a formal, documented process. It is important to discuss the most appropriate option with the person to identify their particular circumstances and preferences. This needs to take into consideration their resources, such as financial resources and the support of family, friends and the community. It should also consider physical and psychological factors, the specific situation, needs and their ability to access services.

Example

Work with the person to determine readiness for the development of an individualised plan

Yvonne is working with Rita to assess her readiness to develop an individualised plan. Rita has been diagnosed with depression, but has been in recovery now for eight months. She is able to understand the planning process and make decisions regarding service provision. Rita feels comfortable working with Yvonne, as they are about the same age and have similar backgrounds. She feels confident that she can express herself and her needs to Yvonne. Yvonne explains the range of services available, and then Rita and Yvonne discuss which service will best meet Rita's identified goal to gain employment.

Practice task 7

1. Explain your understanding of what an individualised plan is.

2. What are the strategies you can use when working with and supporting a person?

Click to complete Practice task 7

2D Determine who needs to be included in the planning process, organise practicalities, and liaise with the assessor of the person's requirements prior to the planning session

It is likely that an individual has used the services of a number of different health and community services professionals, especially individuals with chronic or complex conditions. These professionals can provide you with information during the planning process, such as the person's strengths and weaknesses and particular strategies to meet their needs. Knowledge of other service providers can also help you provide continuity of services, and prevent you duplicating existing services. Alternatively, some of the person's needs may be overlooked if each service provider assumes other service providers are meeting these needs.

You may also need the support of other professionals, service providers and workers to implement the plan. Other people who can offer valuable insight into the person's strengths and weaknesses include family members and friends. These people can also support the implementation of the individual plan.

Review existing files

The task of identifying stakeholders can be overwhelming. Referral letters and reports from doctors and other specialists can help you identify who can provide you with advice about the person's needs and develop strategies to meet these needs.

You may be able to review existing documents and a person's file to draw on existing information that has been gathered for other purposes. Some organisations have a section on the personal details form that invites clients to disclose their specialists. You may have case notes that indicate who has been involved in the client's care and the role these people have played.

v0265

Use genograms

Gathering information is an important part of your role when working towards an individualised plan. It is likely you have a number of people in your case load, so you must record all important information. Record-keeping requirements are vital in the community services sector. Sometimes it can be hard to extract the required information from all of the documents you have on file. Visual representations can be a good way to highlight important information. Genograms are a tool used by people in the community services sector to map people's relationships.

The following symbols are used when creating a genogram.
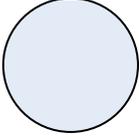
Example	
⬤	A circle represents a female
▢	A square represents a male
△	A triangle represents someone the client has a professional relationship with
⌂	A house shape represents an institution or organisation the client is connected to
——	A straight line represents a positive relationship
– – – – –	A dotted line represents a distant relationship
—//—	A broken line represents a broken relationship
⋀⋁⋀⋁⋀	A jagged line represents a hostile relationship
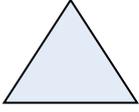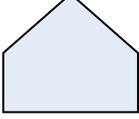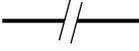
A genogram

Here is an example of a genogram.
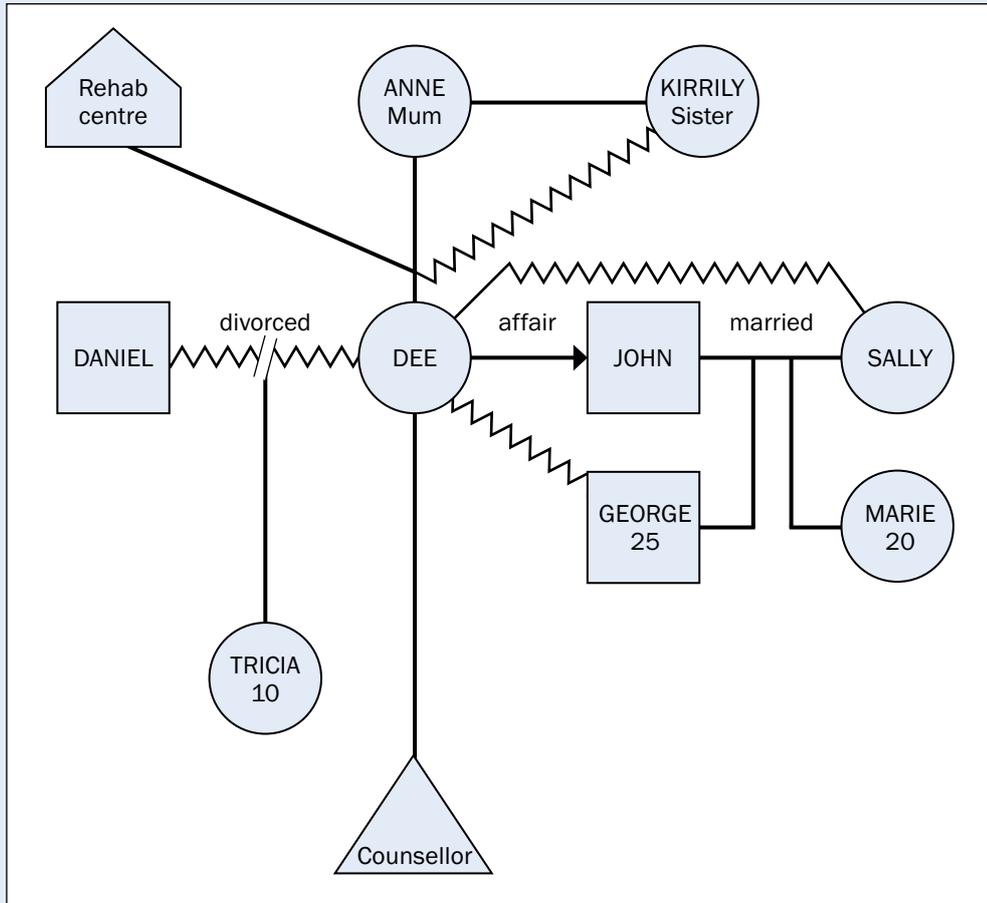
Prepare a relationship map

Another visual tool for identifying stakeholders is a relationship map. Both genograms and relationship maps can be created by the worker and person together. This can be a useful way to develop trust, as well as discussing the person's support networks in a non-threatening environment. A relationship map helps you and the person to identify their support network, as well as the various types of relationships they have and maintain. Here is an example of a blank relationship map that can be completed.

ME

Who am I closest to?
Who are my friends?
Who do I know to say hello to?
Who is paid to be in my life?
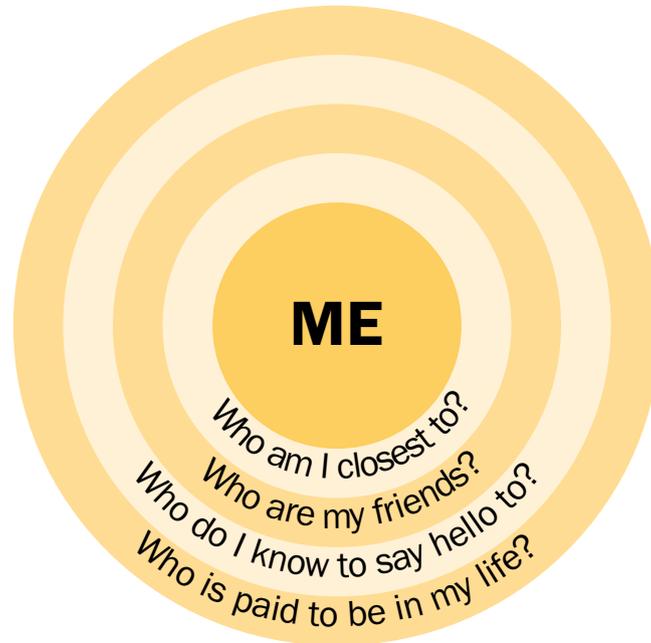
Include others in the planning process

Depending on the person's circumstances, it is important to involve significant stakeholders in the planning process. The people who might be included are the person's assessor, their carers and support workers, health professionals, and other service providers/workers who are involved with the person. It is also important to include other significant people in the person's life, such as family members, friends, neighbours, or community and religious leaders.

You will also need to decide with the person how each of these stakeholders will be involved in the planning process, and what their roles and responsibilities will be. These roles can include providing written information, participating actively in the planning, or simply being available for support during the process.

Assessor

The person's assessor will have assessed the person's needs and eligibility for service provision based on relevant legislation.

The assessor's role and responsibilities are:

▶ to provide information regarding eligibility, including the type and amount of service provision to the person, and to you, to assist in developing the individualised plan

▶ to record assessment findings accurately and clearly so there can be no confusion when someone else accesses the completed assessment at a later date

▶ to refer the person to be assessed by a health professional if assessment is beyond the scope or expertise of the original assessor.

Carers

Carers can be professionals, or family members and friends who are taking on caring roles. Carers have intimate knowledge of the person's needs and abilities, and can provide invaluable information regarding care requirements and the person's strengths. Carers are also likely to be involved in the implementation of the individual plan, so it is useful for them to be involved in its development. This might mean agreeing to the support they will provide to the person. It is important to discuss the involvement of carers with the person, to ensure they are comfortable with who is involved in the planning, and what level of input they will have during the process.

Other support workers

It is the role of support workers to work in partnership with the person to identify their needs and goals as part of the planning process. It is the responsibility of the support worker to provide accurate, clear information on the needs and services provided to the person. The amount of involvement and the responsibilities of each support worker will be dependent on the type of service they provide to the person. For example, it may be important for a worker who provides the person with daily living tasks to be involved in the planning process. It may be less necessary for the person who does garden maintenance once a month to be at the planning meeting.

Health professionals

Depending on the person's situation, they may have a variety of health professionals involved in their lives. The roles and responsibilities of these health professionals is dependent on the level of involvement they have, and the services they provide. Below are some examples of health professionals.

General practitioner

▶ A doctor or general practitioner may have a long-term relationship with the person. They will have access to medical records with information on health issues and chronic illnesses, and will have knowledge of all medical treatments the person is receiving.

▶ Role and responsibilities could be to share this information prior to the planning session, with the person's permission.

Psychiatrist/psychologist

▶ A psychiatrist or psychologist has information regarding the person's mental health and their ability to participate in the planning session and implementation of the plan. They will have information on the person's mental health treatments and may be able to share information regarding the person's strengths and abilities.

▶ Role and responsibilities could be to share this information prior to the planning session with the person's permission. It may be appropriate for them to participate in the planning session.

Community nurse

▶ A community nurse has knowledge of the person's treatment schedule and medical needs and may have a long-term relationship with the person.

▶ Role and responsibilities could be to share information prior to the planning session, with the person's permission and identify known strengths and abilities. It may be appropriate for them to participate in the planning session.

Other service providers

Discuss with the person you are supporting any other service providers they may be involved with. It is important to include information from these other service providers in the planning process. With the person's permission, you should request information regarding the person's care to be sent prior to the planning session.

It is the responsibility of other service providers to provide clear, accurate and current information to support the planning process. They should also provide information on the type and level of services they are providing to the person.

Service delivery workers

During your discussion with the person regarding services that they are receiving, you may agree that it would be useful for specific service delivery workers to participate in the planning process, either by providing information or attending the planning session. Their role and responsibilities would be to provide information regarding the person's strengths and capacity, and perhaps to support implementation of the plan.

Service delivery workers include:

▶ mental health workers
▶ social workers
▶ local area coordinators
▶ dietitians.

Organise practicalities

Ensuring that the planning session goes well, and that it is not stressful for you or the person, is often dependent of organising the practicalities.

Some practicalities to consider include:

▶ finding a time and date that works for everyone who will be attending the planning session and ensuring that everyone is informed and reminded

▶ booking an appropriate venue like a meeting room at your organisation, or meeting in the person's home if this is more comfortable for them – ensure that the venue is accessible by everyone who will be attending

▶ making sure that you and the person you are supporting have access to transport to the planning session.

Liaise with the assessor

Prior to the planning session, you should have completed any assessments needed, or arranged for these to be done by an appropriate health professional. In some cases, it is appropriate for you to undertake the assessments yourself. This is the case if conducting assessments forms part of your job role, you have sufficient time and the assessment does not require specialist knowledge.

In other cases it may be appropriate to delegate the assessment to others. For example, if the assessment does not require special skills, you may consider asking a support worker to undertake the assessment. In other instances, you may need to seek the help of specialists who have the required skills, knowledge and qualifications to adequately assess the client's medical condition and health status.

Keep in mind that most people receiving disability services will require a formal assessment conducted by a government assessor in order to be eligible for service provision.

Assessment tools

Make sure you conduct any assessments well ahead of the planning meeting so you can provide relevant and current information. Some assessment you can undertake, while others need to be done by a qualified health professional. If you carry out the assessments yourself, you must make sure you record your findings accurately and clearly so there can be no confusion when you or someone else accesses the completed assessment at a later date. Information about a range of assessment tools that can help you identify a client's needs is outlined below.

Personal information forms

▶ Personal information form contain identifying details about a person, name and telephone number of the person's emergency contact, and information about current and past medical conditions.

Functional ability forms

▶ Functional ability assessment form assess a person's ability to carry out activities of daily living, such as ambulating, transfer, continence, bathing and showering, grooming and dressing. Examples include the Bartel Index and Katz Index of activities of daily living.

Health assessment questionnaire

▶ The health assessment questionnaire builds on the medical information contained in the person's personal information form. It allows the person to self-assess the health and wellbeing of all of the body's systems including:

- respiratory
- integumentary
- cardiovascular
- gastrointestinal

- urinary
- genito-reproductive
- endocrine
- central nervous.

▶ These forms are written in plain language, making it easier for non-health professionals to understand the questions.

Psychosocial need forms

▶ Psychosocial need forms allow people to self-assess the quantity and the quality of interactions with others.

Mental health forms

▶ Mental health and wellbeing forms ask the person to disclose their sense of satisfaction, their energy levels, fear, general outlook, optimism or pessimism and their engagement in daily activities. Answers to these questions can signal serious mental illness such as depression.

Mental status exam

▶ Mental status examinations are used to assess the older person's cognitive ability (their ability to think). Cognition includes short- and long-term memory, intellectual ability, attention and reasoning.

Example

Determine who needs to be included in a person's support program

Makala, an aged care worker, is concerned about the mental health of one of her clients – Mrs Bernd. She refers Mrs Bernd to a GP for further assessment. Two weeks after the scheduled appointment time, Makala is concerned that she has not received any feedback. She checks with Mrs Bernd who assures her that she attended the appointment and gives permission for Makala to call the surgery on her behalf to enquire about her results.

Makala calls the doctor's surgery. The doctor is unable to take her call, so Makala leaves the following message with the receptionist: 'It is Makala Schmidt from Ocean Way Aged Care Assessment. I am ringing in regard to Mrs Antonia Bernd. I can be contacted on 0400 220 774'.

Later that day, the doctor calls Makala. They have the following conversation:

Doctor: This is Doctor Benson. I am ringing to return your call about Mrs Bernd.

Makala: Thank you. We are in the process of developing a care plan for Mrs Bernd. She seems quite flat and I want to make sure we don't overlook any conditions that may impact her health and wellbeing.

Doctor Benson: Mrs Bernd is showing signs of depression. I have prescribed antidepressants and have also referred Mrs Bernd to Jane Jones – a psychologist for counselling. I have written this in a report, which I will send to you today.

Makala thanks Doctor Benson and then provides her contact details. She later checks that the report has arrived.

Practice task 8

Read the case study, then complete the task that follows.

Case study

Lloyd is about to move from his parents' home into a supported accommodation facility. This is the first time Lloyd has lived away from home and he will miss his parents and younger sister. Lloyd still sees the same GP his family has been accessing since he was a young child and Lloyd feels very comfortable with Dr Frank. Lloyd's family have been working with a local area coordinator for the past 18 months and she is the person who has helped Lloyd work towards his goal of more independent living.

Anna is working with Lloyd to develop an individualised plan to support his needs and goals.

1. List four people that Lloyd and Anna might involve in the planning process.

2. Describe the role and responsibility of each in the planning process.

Click to complete Practice task 8

2E Collate and prepare information and distribute to relevant stakeholders

Prior to the planning session, you need to make sure you have all the required documentation. Beyond agendas and the person's information, this may include assessment forms, consent forms and referral forms. In all instances you need to follow the organisation's requirements and processes for selecting the appropriate form and completing it correctly. For example, your organisation will have templates that can be used for meeting agendas, assessments and to develop individual plans. Templates can vary between organisations, and the specific information may also vary slightly to reflect the focus of the planning tool. Make sure you are familiar with the form's layout and know what information is required.

Collate and prepare information

Formalised templates are efficient and effective. Complete all sections of the individual template. This prevents you from missing important information. It also helps others who use the agenda, form or plan. Over time, people get accustomed to quickly accessing the information that is relevant to them. If you change the format, you risk creating confusion.

Common inclusions in templates are:

▶ the date the plan was created and who created it

▶ the person's name and date of birth

▶ conditions impacting the plan

▶ the person's goals and desired outcomes

▶ the strategies designed to achieve these goals

▶ those responsible for implementing the strategies

▶ the resources needed to implement the strategies

▶ a review date for the plan.

Distribute information to stakeholders

Once you have collated all the relevant information, it is important that you share this information with relevant stakeholders before the planning session, so they can come prepared. There are a variety of distribution methods that are available, and you should consider issues like confidentiality and privacy, as well as the stakeholder's access to technology when deciding on a method.

Below are some methods you could use to distribute information.

Email

Email is a fast and efficient way to send documents of various sizes and can allow you to check that messages have been opened/received. When using email as a method of distributing information, consider confidentiality issues, and the fact that not all stakeholders have access to email or check it regularly.

Mail

Mail provides access to information for stakeholders who do not access other technology. Consider the time frame for delivery, and ensure mail is marked as confidential.

Fax

Faxing is fast and useful for sending handwritten material. You will need to consider confidentiality if this is a shared machine. This technology is no longer commonly used, so not all stakeholders will have access to it.

Text messaging (SMS)

Text messaging may not be accessible to all stakeholders, and you cannot send large attachments via this method. However, it is good for reminding stakeholders of time, date and venue for a planning session.

Example

Collate and prepare information and distribute to relevant stakeholders as required

Mark collates and prepares all the relevant information and documentation prior to a planning session with Pete. Two weeks prior to the meeting, Mark sends out information by email and mail to relevant stakeholders, inviting them to the meeting and providing them with information regarding the date, time and venue. After confirmation of attendance is received, Mark sends out copies of the information each stakeholder will require in order to be prepared for the meeting. Mark emails this information to stakeholders who have private email addresses and sends it out by mail to Pete's parents, who do not have email. Two days before the meeting, Mark sends a reminder by text message and email to all stakeholders.

Practice task 9

1. Why are templates useful in preparing for planning?

2. What are four ways you can distribute information to stakeholders prior to the planning session?

<div style="text-align:center">

Click to complete Practice task 9

</div>

Summary

1. Explore the physical and psychological factors related to the person's life stage that will influence service delivery.

2. Explain why the planning process is important to the person and discuss service delivery options.

3. Alongside the person, assess their readiness for an individualised plan.

4. Find out who needs to be involved in the planning process and what their roles will be.

5. Organise any practicalities regarding the planning process.

6. Gather and prepare information for the planning process and distribute to relevant stakeholders.

Learning checkpoint 2
Prepare for planning

This learning checkpoint allows you to review your skills and knowledge in preparing for planning.

Part A

1. Why is it necessary to explain the purpose of the planning process to a person in need of services?

2. Identify the factors that may impact a person's readiness to prepare their plan.

3. What are the practicalities you should consider when organising a planning process?

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

4. Identify the types of information that may need to be collated and prepared prior to the planning session.

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

Part B

Read the case study, then answer the questions that follow.

Case study

Rick is 19 years old and has an acquired brain injury from an accident two years ago.

1. Why is it important to consider the physical and psychological factors relevant to Rick's life stage when planning service delivery?

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

. … … ….. … … ….........

2. Who might need to be involved in the planning process for Rick's service delivery?

3. Give three examples of service options and their features that could support Rick.

Topic 3

In this topic you will learn how to:

3A Respect the person's perspective, foster their strengths and capacities, and promote their participation

3B Follow process requirements of service planning tools

3C Identify and confirm key aspects of individualised service delivery by working collaboratively with the person and other stakeholders

3D Consider interrelated needs of the person and plan an integrated approach to service delivery

3E Conduct risk assessment specific to the person's circumstances, discuss and work collaboratively with person to minimise risk

3F Manage any conflict or differences with regard for the person's perspective

Plan service delivery

There are a number of factors to consider when planning service delivery alongside a person. You need to promote the person's participation and treat them with respect while focusing on their strengths and abilities. You will need to include significant stakeholders in the process and manage any differences or conflict with regard for the person's perspective. For a person with complex or multifaceted needs, the plan will need to include an integrated approach to service delivery. You will need to consider the risks for the person and work together towards minimising identified risk.

3A Respect the person's perspective, foster their strengths and capacities, and promote their participation

In order for the service delivery planning process to be useful, you need to be able to listen to, and respect, the perspective of the person you are supporting. At times your perspective on the person's situation and needs may differ from the person's and it is important to remember that the person has ownership of the plan. The focus of service delivery planning in the past has often been the person's deficits or problems. We know that it is important to focus instead on the person's capacities and strengths in order to support good outcomes.

Respect the person's perspective

You can demonstrate respect for the person's perspective by actively listening to their thoughts, feelings and ideas regarding the service delivery plan. The person may feel overwhelmed being at a meeting with other people, and may be reluctant to voice their opinion or disagree with the options suggested. Your role is to support the person to express their views and to encourage other stakeholders to listen and acknowledge what the person says and show empathy for their decisions.

Foster the person's strengths and capacities

Every person you work with will have particular strengths, in fact many of them will be doing quite well in spite of their circumstances. Your role during the planning process is to support the person to identify these strengths and to support them to develop a plan that will build on these strengths. Talk to the person about what they think their strengths are, and include their family members and carers in this discussion. Talk about the person's aspirations and prior achievements and encourage them to consider their ability to learn and grow. Remember to think about strengths broadly in terms of the resources the person has, both internally and externally; for example, a person with good family support has that as a strength.

It is not uncommon for organisations or workers to focus on the deficits of the person, what they are not able to do or what their issues are. The service delivery plan will be more successful if you are able to focus on the person's capacities, what they can do and what they do well.

Promote the person's participation

It is important that in the planning process you are able to focus on what is important to the person now and in the future. Knowing that you understand their situation and perspective will encourage the person to participate. Here are some additional suggestions to support a person's participation.

Practice

Practice what the person wants to say before the meeting, or support the person to bring written notes.

Time

Ensure that time and space is given to support the person to speak, encourage other participants to listen carefully.

Person's needs

Consider the person's needs during the meeting – Do they need regular breaks? Would it be better to plan over a series of meeting rather than one long meeting? Is the language appropriate?

Communication

Ensure all communication is clear and that the person has understood it.

Understanding

Ensure the person understands what to expect prior to attending the meeting.

Approach to planning service delivery

The approach you take to planning service delivery can have a significant impact on the process and on the outcomes of the planning. A person-centred approach ensures that the person's perspective and goals are at the forefront of the planning process. A strengths-based approach focuses on a person's abilities and strengths, rather than any deficits they may have. A family-centred approach acknowledges the centrality of families in the life of a person.

Person-centred planning

Person-centred planning is a process of listening and learning. The worker focuses on what is important to the person now, and how they would like their future to be. It is also important to include people who are significant to the person in this process, such as family, a partner or friends.

Some process requirements for person-centred planning are listed below.

Person-centred planning requirements

▶ The respect and understanding of the person

▶ Giving priority to the person's preferences and choices

▶ Holding the person in positive regard

▶ Working with the person to envision the future using creative strategies

▶ Supporting the person to gain access to community resources

▶ Ensuring that the person is empowered and supported

Strengths-based approach

A strengths-based approach is a way of working that recognises the resilience of individuals and focuses on their abilities, their knowledge and skills, their interests and their strengths. This differs significantly from traditional deficit-focused approaches. This approach also recognises the importance of the person's environment and the situations that impact on their lives.

A central component of the strengths-based approach is collaboration between the person and the worker. Developing a trusting working relationship is essential to the process. The planning process is managed as a partnership between the worker and the person.

The assessment process, using the strengths-based approach, begins this relationship building as well as empowering the person to begin identifying their strengths.

Strengths-based assessment:

▶ measures the skills, competencies and characteristics that create a sense of accomplishment for the person

▶ identifies what contributes to the person having satisfying relationships with family, friends and members of the community

▶ identifies what enhances the person's ability to deal with stress or adversity

▶ identifies what supports the person's development (personal, social and cognitive)

▶ establishes positive expectations for the future

▶ empowers the person to take control over decisions affecting their life.

Family-centred planning

Family-centred planning recognises that for many people, family plays a central role in their lives. Much like person-centred planning, respect for the person and their family is vthe basis for this approach. It acknowledges that supports provided, or not provided, can impact on the whole family not just the person receiving services. It explores the support family can provide to the person, and how the plan can support the strengths of the family to meet the needs of the person. This means that family members are actively involved in the planning process, and each family member present needs to be listened to and encouraged to participate in a manner that is supportive to the person. The planning process needs to build relationships with family members, support choices of the family and provide family members with good information.

Example

Respect the person's perspective, foster their strengths and capacities, and promote their participation

Greta is facilitating a service delivery planning meeting for Trudy. Initially Trudy is very quiet and seems uncomfortable that the meeting is about her. Greta encourages Trudy to participate at each stage of the planning meeting, checking to ensure that Trudy agrees with what other stakeholders have said, that she understands her options and that she is able to make decisions that will be documented in the plan. Greta asks Trudy's opinion on service delivery options and listens carefully to her responses. Greta often summarises or paraphrases what Trudy has said to ensure she has understood correctly.

Practice task 10

1. Explain the ways to support a person's participation in service delivery planning.

2. Describe the components of strengths-based assessment.

Click to complete Practice task 10

3B Follow process requirements of service planning tools

Your organisation will have one or more service delivery planning tools that can be used to support the planning process. Each of these planning tools have process requirements which you will need to follow to gain the most benefit from the tool.

You will need to determine your organisational requirements. Check with your supervisor to find out how to access the appropriate tools. Below are some factors you need to consider before preparing the plan.

Organisational services

Be familiar with what your agency or organisation offers, and what other services are available from other organisations. Some organisations and agencies focus on specific sectors. For example, some providers focus on housing while others focus on education and training. If you are working for a specialist agency or organisation, you are limited to care plans that have your agency focus.

Making referrals

If the services your agency provides do not meet the needs of the client, you have an obligation to refer them to another appropriate provider. Even if you are working for an organisation that offers a broader range of services, you still must follow your organisation's policies and procedures when it comes to selecting the most appropriate planning option.

Select appropriate planning tools

You need to work with the person to identify the planning options that work best for them. Some individuals enjoy using MAPS, PATHS or Personal Futures planning. These approaches allow for a great deal of flexibility, which can be overwhelming for some individuals. In these instances more structured planning processes are more appropriate. In some instances a more narrowly focused plan is suitable; for example, if a person needs a rehabilitation program or if they have a specific target such as to increase their social interaction.

Person-centred planning processes

Many individualised plans are developed using forms and templates. Forms and templates are useful as they help workers identify and gather crucial information, but you should be aware that a formal plan is not always needed and may not suit the purpose. This is particularly true in instances where the plan covers a goal or activity that is relatively minor.

Person-centred planning processes include tools that support a person to develop an individualised plan that focuses on their strengths. Tools that are commonly used include MAPS, PATHS or Personal futures planning.

MAPS

MAPS stands for Making Action Plans. The following steps explain the process that should be followed when facilitating individual plan development using MAPS.

1. Identify and arrange a meeting of the stakeholders. The key stakeholder should always be the person receiving services. Other stakeholders can include family members, friends, carers, health professionals and teachers.

2. Give the person time to outline their history and to describe themselves. This helps the people involved with the person begin to understand their views and values, as well as their concept of themselves and their feelings of self-worth.

3. Ask the stakeholders to describe their hopes and dreams for the person.

4. Ask the stakeholders to share their fears about the person's future.

5. Ask the stakeholders to share their views about the person's strengths and positive qualities.

6. Ask the stakeholders to share their views about barriers the person may face in achieving their dreams.

7. Brainstorm needs the person may have.

This process helps the person identify their goals and develop strategies to achieve their goals. It also helps create a team of people who have positive regard for one another and are able to work effectively with each other.

PATHS

PATHS stands for Planning Alternative Tomorrows with Hope. PATHS is a process where a person is encouraged to develop reflective and action skills to help improve their wellbeing.

PATHS involves the following steps:

1. Ask the person to reflect on their current situation.

   ▶ What do they do?
   ▶ Who do they do it with?
   ▶ How does it make them feel?

2. Ask the person to brainstorm what their perfect world is like. These are often referred to as their 'dreams'.

   ▶ What are they doing?
   ▶ Who are they with?
   ▶ Where are they?
   ▶ How are they feeling?

3. Ask the person to consider what they need to do to achieve their goals.

   ▶ Do they need to increase their skills?
   ▶ Do they need to change their behaviour?
   ▶ Do they need to improve their knowledge?

4. Ask the client to consider what they need to achieve their goals.

   ▶ What physical resources do they need?

   ▶ What human resources do they need?

5. What will they do in the short term to achieve their goal?

6. What will they do in the medium term to achieve their goal?

7. What will they do in the long term to achieve their goal and dreams?

Personal futures planning

Personal futures planning is normally used with young people with disabilities who are about to make the transition from schooling to adult life. Coordinators work with young people to identify what they would like to do after secondary schooling and how they can achieve their goals.

Example

Following process requirements of service planning tools

Mick, 45, has a drug and alcohol problem and feels his life lacks focus. He meets with his case manager and together they develop the following PATH to help Mick focus his attention and improve his health and wellbeing.

Now

▶ Drinking

▶ No money

▶ Arguments

Dreams

▶ Travel

▶ Good income

▶ Good relationship with wife and kids

What I need to do

▶ Spend more time with my family

▶ Stop drinking

▶ Get a job

People who can help

▶ Family

▶ Counsellor

▶ Employment services manager

The first step

▶ Contact drug and alcohol service

▶ Apologise to family

▶ Undertake career counselling

Medium-term plans

▶ Participate in relationship counselling

▶ Reskill

Long-term plans

▶ Seek and secure employment

Practice task 11

Work with a person in need or services, or ask a friend or family member to play the role of a person needing services. Undertake person-centred planning using PATH as a framework. Use this table, develop your own or use a template you are familiar with.

Now	
Dreams	
What I have to do	
People who can help	
The first step	
Medium-term plans	
Long-term plans	

Click to complete Practice task 11

3C Identify and confirm key aspects of individualised service delivery by working collaboratively with the person and other stakeholders

You will need to work with individuals to identify and confirm what aspects of service delivery are key to meeting their needs. You can do this by working collaboratively alongside the person to explore their needs and service delivery options and to establish goals that will meet those needs and support the person. This places value on the person's perspective regarding service delivery and empowers them to make decisions regarding their goals and activities. It also ensures that the person is motivated to participate in the service delivery.

Communicate effectively

Effective communication is essential for ensuring that the service delivery plan meets the needs of the person, and that all stakeholders feel heard and understand the process and their roles and responsibilities. Two ways to contribute to effective communication is by using active listening and questioning.

Questions can be open or closed. Closed questions usually solicit a 'yes' or 'no' response or limited information like 'How old are you?' An open question encourages a full and meaningful response, and allows the person to express their feelings and thoughts. You should consider the impact each of these types of questions will have on your communication with a person.

Active listening requires:

▶ using body language, like nodding, to indicate you are listening

▶ good eye contact

▶ use of paraphrasing to check understanding

▶ open body language

▶ asking questions to clarify meaning

▶ summarising what the person has said

▶ being non-judgmental.

Plan individualised service delivery

We have established how important it is for each person to have a plan that meets their individual needs and capacities in order for service delivery to be effective. Planning for individualised service delivery is a process that requires a series of steps.

These steps can be seen below.

Individualised service delivery planning process
1. Establish goals
2. Develop actions and strategies
3. Match resources
4. Determine outcomes
5. Make variations
6. Transition to other services
7. Exit services

Establish goals

The basis of a service delivery plan is establishing what the person wants to achieve or do, or what needs can be met, now and in the future. In other words you need to work collaboratively with the person, and other stakeholders as appropriate, to establish goals. Keep in mind that it is easy to set goals – think how many people make New Year's resolutions – but it is harder to make goals that are meaningful. Good goals motivate the person to move forward and to work towards meeting them. Motivational goals are goals that are SMART: Specific, Measurable, Achievable, Realistic and Time-framed.

SMART GUIDE
An easy-to-remember guide for setting objectives:
S	**Specific** Target and clearly define a specific area that you want to improve.
M	**Measurable** Suggest an indicator of progress; quantify if possible. Determine how you will know the goal has been achieved
A	**Attainable** Agree what the goals should be and keep them achievable in the time frame.
R	**Realistic** Identify what results can realistically be achieved given the available resources, knowledge and time.
T	**Time-framed** Specify when the result can be achieved; make sure there is enough time to achieve the goal, but not too much time.

Motivational goals

In order to make sure that goals are meaningful and SMART for the person you are working with, you should consider the following.

Gather information about the person

▶ Who is important to the person?

▶ What do they want to do now and in the future?

▶ What are their strengths?

Learn what is important to the person

▶ What relationships, artistic endeavours, social activities, sporting activities, life events, and achievements are important to the person?

▶ What are they good at or enjoy doing?

▶ What would they like to learn or try?

Balance risk and happiness

▶ Achieving goals often means taking a risk of some sort; for example, trying something new or learning a new skill could include the risk of failure. This needs to be balanced against the potential happiness of achieving goals.

Explore culture and spirituality

▶ Discuss the importance of the person's culture and spirituality with them and consider how this will influence the goals you set. For example, if the goals are not in line with the person's cultural or spiritual values they may not be motivated to work towards them.

Build relationships

▶ Consider what relationships the person already has that can support them to reach their goals. Then discuss with the person who else may support them. Perhaps joining a social club would help build confidence, or joining a sporting group may build social connections.

Develop actions and strategies

Once you have established goals collaboratively with the person, the next step in the planning process is working out how to achieve those goals. What strategies or actions will support working towards a positive outcome. For example if the person's goal is to get a driver's licence, what actions would be required? Perhaps consider hiring a driving instructor, getting the learner's driving manual to study, or enlisting the help of a family member or friend to practice driving with.

The strategies selected should be realistic and take into account limitations such as finances, your organisation's policies and procedures and the person's capability. You must make sure that all required resources are available.

Match resources

The goals in an individualised service delivery plan will require resources to achieve. These resources could be friends, family, community groups, health professionals or support workers, who provide general support or can provide specific services. Resources can also be physical resources such as money, time, transport, technology, physical or education. You will need to work with the person to identify the resources required and to find strategies to access these resources as required.

Determine outcomes

An individualised service delivery plan is only effective if you and the person know what outcomes you are aiming towards and what 'success' will look like. This should be done as part of the planning process and should be follow up on regularly.

Here are some examples of goals and the linked outcomes.

Goal	Strategies	Resources	Outcomes
I want a job where I can get paid to work with my hands.	Explore volunteering opportunities to gain experience.	Myself with support worker, one hour per week until opportunity gained.	I have visited places where I could volunteer and chosen one I like. I have spoken to the manager and arranged a meeting next week.
I want to stop smoking.	Get information on smoking cessation options. Choose an option.	Quit campaign information. Support worker to discuss options. Nicotine replacement if required.	I have implemented the strategy and have stopped smoking.

Make variations

Individual plans must be dynamic. This means they must change to reflect changes in the person's circumstances. You should respond to changes in the person's condition or situation by discussing the situation with them. A person's circumstances can change in any one of a number of ways, some of which are considered here.

Living arrangements

The person may move house, which can:

▶ create additional transportation needs or alternatively decrease transportation needs

▶ increase or decrease their support network

▶ create the need for additional home modifications.

The person may get divorced, or their partner may move out or pass away, reducing the amount of support they have access to in their home. Alternatively, the person may move in with another person, decreasing the support they need from paid carers.

Financial position

The person's financial situation may change due to retirement, gaining or losing a job, changes to Centrelink eligibility or payments, or receiving an inheritance or payout.

Changes in health

The person's health may improve. They may recover from an illness or injury, meaning they no longer need as much support. Alternatively, the person's health may deteriorate if their condition worsens or they develop new conditions that require further or different support. The person may have an accident that impacts on their support needs.

Transition to other services

For a number of reasons a person may transition, or move, to other services from your organisation. This may be because they choose to access another service, because their needs or circumstances have changed, or because they have achieved all their goals with your organisation and no longer need your support, but do need support with other issues.

During this process the person needs clear and accurate information about the new service and the process of transitioning. The person may need your support to meet new workers and to access the new service. They may need access to their information to take with them to the new service.

The transition process can be challenging, especially if the person does not want to change services because they feel comfortable with your organisation. It is important to listen to any concerns and to support the person through these changes.

Exit services

Like the transition process, exiting a service can be challenging for the person. They may be nervous about the changes, or upset that they will no longer be receiving services from you. On the other hand, for some people this is an exciting time if they feel they have achieved their goals that they set with you. Here are some things to consider when a person is exiting a service.

Things to consider when exiting a service

▶ What information does the person need regarding the exiting process? How will they be informed?

▶ Do they need to be referred to other services? Inform the person of options available.

▶ Do significant people in their lives (like family or carers) know about the process?

▶ Include the person as much as possible in the decision to exit services.

▶ Ask for feedback on the services provided.

Example

Identify and confirm key aspects of individualised service delivery

Rhonda is in a domestic violence women's refuge. Her support worker Laura organises to have Rhonda's children cared for by a children's advocate so they have time to establish what Rhonda's goals are. Rhonda tells Laura that her priority is a safe place to live with her children. She also wants the children to be able to access stable education and not have to keep moving schools.

Laura talks to Rhonda about what resources she will need, and they agree that as Rhonda's mother has been a support in the past it would be a good idea for Rhonda to contact her, even though she lives interstate. They also identify that Rhonda needs legal advice regarding her relationship and put in place a strategy to access a legal service. Finally, they develop a strategy to meet Rhonda's housing goal which includes meeting with government housing to get on the priority housing list, and spend some time together accessing private rental websites.

v1764

Practice task 12

Read the case study, then complete the tasks that follow.

> ### Case study
>
> Dawn has moved into an accommodation service for homeless people and is currently unemployed and has no source of income. Dawn was divorced last year and says she has no friends in the city. Her family lives interstate and she has lost contact with them.

1. List some goals Dawn might want to work towards.

    .   ...

    .   ...

    .   ...

2. Describe some of the resources Dawn will need.

    .   ...

    .   ...

    .   ...

    .   ...

Click to complete Practice task 12

3D Consider interrelated needs of the person and plan an integrated approach to service delivery

Most individuals accessing community services have multiple needs that will be linked or interrelated; for example, a person may have health issues and a lack of transport. These two issues are interrelated as the person may not be able to access health care due to a lack of transport, or their health issues may have developed because they could not access health care. You will need to work with the person to plan an integrated approach, with other services providers where required, to deliver services.

Consider the person's interrelated needs

One way to consider the interrelated needs of an individual is to understand Maslow's hierarchy of needs. In 1943, psychologist Abraham Maslow argued that we all have certain needs, regardless of a person's stage within their lifespan, their ability or disability or impairment, culture or gender. Maslow argued that we must first meet lower level needs before attempting to fulfil higher level needs. For example, if a person does not have accommodation or enough money to pay for food, they are unlikely to develop their intellectual potential fulfilling their self-actualisation needs. This means you must have a full understanding of all aspects of the person's life before you begin to plan for their care.
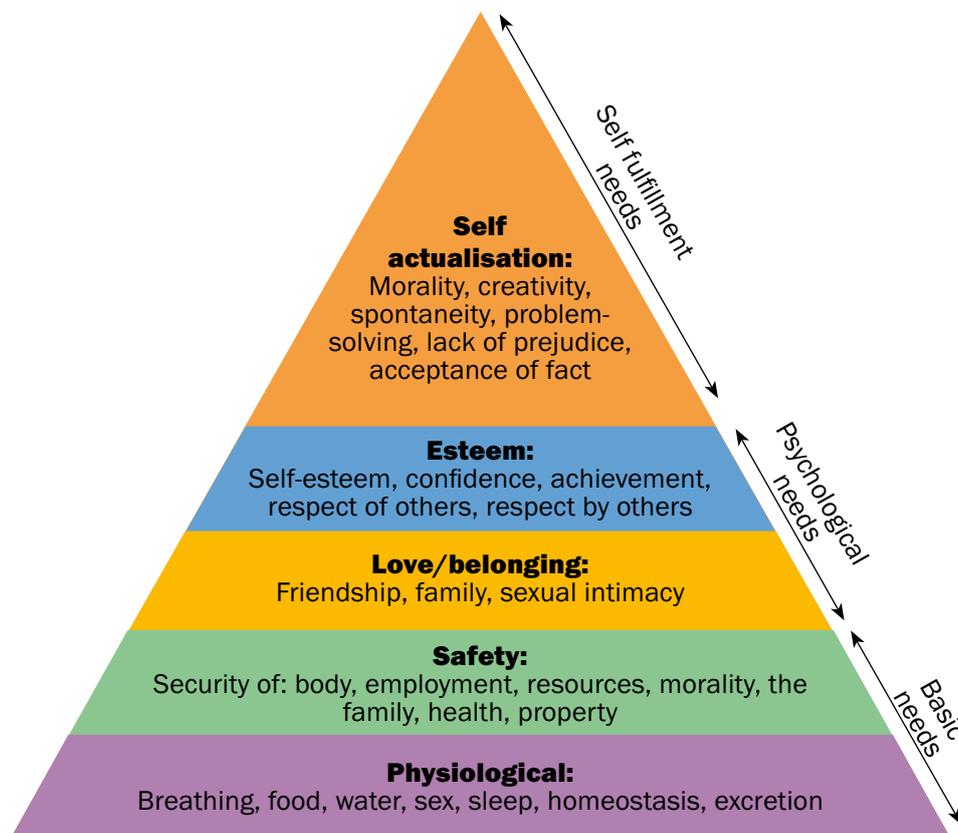
Plan an integrated approach to service delivery

Recognition of how fragmented service delivery has been in the past is driving a call to provide more integrated services that meet the interrelated needs of individuals. Often a person with complex needs will receive services from multiple service providers, all working in isolation. This has led to people receiving duplicate services, or missing out on required services.

A more effective way of providing services is for service providers to collaborate with the person, and each other, to provide integrated services that address identified needs and goals. This means addressing interrelated needs using one service delivery plan rather than several.

Integrated services require:

▶ a commitment from senior levels of government to support integrated services both between government departments and with non-government organisations

▶ a clearly articulated commitment to shared goals and a vision of integrated deliver

▶ provision, where possible, of 'one-stop shops' or 'no wrong door' services – services that are integrated or collaborative

▶ provision of information regarding service delivery to other service providers and to people who require services and their families

▶ having, where possible, one service provider providing multiple interventions, or having a range of services in one location or organisation

▶ embedding specialist services into generalist services (for example having mental health professionals or a GP embedded in homeless drop in centre)

▶ ensuring that service provision is inclusive of culturally and linguistically diverse people, Indigenous Australian people, LGBTI people, people with disabilities and significant others

▶ ensuring that services are accessible to people in need of services

▶ encouraging community participation

▶ providing mentoring to workers to work in an integrated manner.

Example

Consider interrelated needs of the person and planning an integrated approach to service delivery

Service X provides services to homeless people in a capital city. Homeless people can access a daily drop in centre which provides services to meet immediate needs like a meal, hot drinks, laundry and shower services, mail drop off and computer access.

The drop-in centre has integrated additional services into its structure. People accessing the drop-in centre can also access specialist services, such as housing case management, mental health workers, Centrelink officers, a GP, a dentist and legal aid.
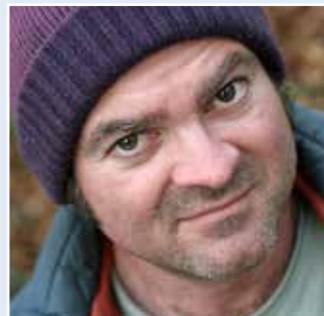
Practice task 13

Read the scenario, then complete the task that follows.

1. Explain how an integrated approach could support these young people to meet their needs more effectively.

2. Describe the things that would be needed to provide integrated services to these young people.

Click to complete Practice task 13

3E Conduct risk assessment specific to the person's circumstances, discuss and work collaboratively with person to minimise risk

People working in community services have to balance two very important rights – an individual's right to autonomy and independence, and their right to a safe environment. To ensure a person's rights are met, workers have a duty of care to identify, assess and take steps to minimise or remove risks; however, they do not have a right to prevent individuals from participating in activities. Risks can relate to the person's environment and the person's health, impairment and behaviour.

Conduct risk assessment

All people are different and live in different environments, each with their own characteristics. Individuals may be at risk because of a medical condition, impairment or their behaviour. You have a duty of care to identify risks specific to a person's circumstances and to take steps to minimise these risks. Risk management should be incorporated into the person's individual plan. Some issues can impact a person's health and wellbeing.

Issues that may lead to a person being at risk include:

▶ weight loss or gain

▶ skin integrity

▶ infection

▶ evidence of self-neglect

▶ behaviours of concern

▶ impaired judgement and problem solving abilities

▶ impaired cognitive functioning

▶ evidence of abuse

▶ social rights infringements.

Signs that a person is at risk

Not all individuals can, or will, verbally tell you that they are at risk; however, their physical appearance and behaviour may indicate that they are. Risk behaviours should be investigated, as they can indicate that the person is neglecting themselves, is being abused or that their human rights are being infringed.

Older people, children and young people, and people with disabilities or mental health issues can be vulnerable to abuse and neglect by others. The abuse may be physical, psychological or financial, involving the infringement of a person's human and social rights. The following shows some of the signs that a person could be at risk of self-harm or a victim of abuse and/or neglect.

Attention-seeking behaviours

Attention-seeking behaviours include:

▶ lying

▶ striving for recognition

▶ constantly seeking sympathy

▶ excessive drama relating to an issue

▶ playing on an injury.

Self-harming or self-injurious behaviours

Self-harming or self-injurious behaviours include:

▶ poking their eyes

▶ hitting their head with their fist

▶ self-biting

▶ cutting themselves

▶ banging their head

▶ slapping their thighs

▶ pulling their hair

▶ scratching or pinching themselves

▶ neglecting their grooming or having poor hygiene, which can limit access to the community or community facilities

▶ substance misuse.

Noncompliant behaviours

Noncompliant behaviours include those that are defiant and disruptive, such as:

▶ yelling or singing loudly in supported accommodation

▶ entering other people's rooms

▶ making constant demands

▶ repeatedly asking questions

▶ distracting or preventing themselves and others from participating in learning and developing new skills

▶ refusing to participate or complete tasks.

Repetitive or self-stimulatory behaviours

Self-stimulatory behaviours may involve perseveration behaviours, which are the uncontrollable repetitions of particular responses, such as:

▶ humming

▶ hand-flapping

▶ covering ears to block sound

▶ making vocal noises/sounds

▶ rocking

▶ skin-picking and scratching

▶ pacing.

These behaviours can prevent the person from engaging in activities.

Agitation

Behaviours include some actions that can last for an excessively long period of time, such as:

▶ fidgeting

▶ repetitive movement

▶ distractedness

▶ persistent scratching.

Some of these behaviours may be self-stimulatory and can isolate the person and interfere with skill development.

Aggressive behaviours

Aggressive behaviours (physical and/or verbal) include:

▶ hitting

▶ yelling

▶ standing over or intimidating others

▶ threatening others

▶ damaging property.

Impulsivity and disinhibition

Impulsivity involves acting on involuntary or uncharacteristic impulses.

Disinhibition involves doing things in front of others or in public that are uncharacteristic or inappropriate and make others feel uncomfortable; for example, undressing or engaging in sexually inappropriate behaviour.

As with self-stimulatory behaviours and agitation, these behaviours can prevent the person from engaging in activities, and they can make others feel uncomfortable.

Depression, confusion and withdrawal

Signs of depression may include constant disinterest and appearing unmotivated – uncharacteristic sadness reduces quality of life and threatens health and wellbeing.

Confusion or disorientation may involve not understanding simple requests.

Withdrawal involves not participating or responding, therefore becoming socially isolated.

Losing weight, changes in sleeping patterns or unusual use of alcohol or other drugs.

Distress, sleeping and eating problems

Emotional distress signs may include crying, wailing and calling out.

The person may have problems getting to sleep, staying asleep or waking alert. The person may appear tired, be lethargic and become more easily annoyed at situations.

Eating problems may include increased or decreased appetite.

Environmental risks

When preparing an individual plan, it is your role to assess the risks inherent to the environment and develop appropriate strategies to minimise or reduce the risk. You need to determine where the activities detailed in the person's care plan should be carried out, and assess the environment to ensure it is made as safe as possible and that potential risks in the environment are identified and managed or minimised. Many workplaces have a formal environmental risk assessment tool that workers must use to assess the care environment, identify risks and plan their management.

Identify and assess environmental risks

Environmental risk assessments must be conducted for every person and for each environment where support occurs. Even if the environment is a facility where support is delivered to many individuals, it is important to assess again for each individual person, as there are varying risks associated with each individual person and their conditions.

Sometimes risks may be very obvious, such as broken equipment or raised pathways. Other risks may be harder to identify and require you to look very carefully. Risks can be identified by observing the environment and checking for issues or items that may cause risk to the person or worker. Keep the person's needs and abilities in mind. You can also talk and listen to the person and their carer about existing or potential hazards.

Determine locations

Determine the locations where a person may be exposed to risk by referring to the person's individual plan. People receiving services live in and visit a range of environments. The following list contains some examples of locations that can be included on a person's individual care plan.

Locations may include:

▶ a person's own home

▶ shared accommodation in the community

▶ respite centres, hostels and nursing homes

▶ community centres or service agencies

▶ gyms, pools and fitness centres

▶ churches

▶ pubs, clubs and entertainment venues

▶ workplaces, schools, training providers and universities

▶ health professionals' offices

▶ public transport, taxis and cars.

Safety of access issues

Once you have identified the locations that need to be assessed, you need to determine the types of risks the person may face. Consider the safety of access in homes and building; for example, persons who are frail or have balance or mobility issues require areas that have handrails, few or no steps and smooth pathways to assist their access to areas of the home or building. If the person uses a wheelchair, they need ramps and possibly lowered door handles. It is important that all entries and exits in and out of the building are accessible, and all rooms have clear and safe access, including more than one exit. In looking for risk issues to do with access, consider the points below.

Potential access risks
▶ The condition of the road to access the house
▶ Whether the house number is clearly visible from the street
▶ Whether the outdoor lighting is adequate
▶ Whether footpaths and driveways are even and clear of overhanging branches
▶ Whether steps are safe and not slippery
▶ Whether ramps are in place, where required, and are in good condition
▶ That handrails are in place, where required, and are firmly secured and in good condition
▶ Whether floors within the home are clear of clutter, rugs, cords and so on
▶ Whether locks, doorhandles and windows are functional and easy to operate
▶ Whether entries and exits are clear

Slippery or uneven floor surfaces

Floors that become wet or have substances spilt on them can put people at risk of slipping. You should identify areas where this may occur, such as bathrooms, kitchens

and outdoor areas and ensure measures have been taken to prevent slipping, such as non-slip surfaces, mats and regular cleaning. Floors that are uneven can also put people at risk of tripping and falling.

To avoid floor surface risks:

▶ ensure floors are clear of objects

▶ make sure floor surfaces such as carpet, linoleum and tiles are smooth and have no tears, fraying seams, cracks or areas where flooring has lifted

▶ check that joins between floor surfaces are flat and not loose; for example, in doorways where carpet meets tiles

▶ ensure outdoor pathways are smooth with no raised areas or cracks

▶ remove rugs in the home that may cause tripping.

Home maintenance and temperature

It is important that a person's home is well maintained to prevent injury or harm to themselves, or to workers and others. Ensure you assess the maintenance of the home.

When assessing the maintenance of a home, check whether:

▶ the home is clean and tidy

▶ outdoor paving is even and clear of weeds and plants

▶ light bulbs are in working order

▶ appliances are in safe working order

▶ doorhandles, taps, etc. are all working and are easy to use

▶ doors, including shower screens, are easy to open and close

▶ equipment is in good working order and is regularly checked and maintained.

Inadequate heating and cooling devices

People who are older, young children or who have disabilities may have trouble maintaining their body temperature appropriately – they may feel too cold or too warm. It is important to assist them with their health by ensuring that their home has appropriate heating or cooling to maintain a comfortable temperature. This can be especially important in times of extreme high or low temperatures, in summer and winter. Check that the home or residence has heating and cooling appliances that are safe, easily controlled and maintain a comfortable temperature through the home. When the person uses other heating or cooling appliances, there are things that must be checked.

When assessing heating and cooling devices, check:

▶ the appliance cannot easily be tipped or knocked over

▶ power cords are not frayed and are not across walkways or floors

▶ the appliance is not covered or blocked by materials or furniture

▶ the person can easily control the appliance

▶ the appliance does not emit noxious or dangerous fumes or gases

▶ the area is well-ventilated.

Inadequate security

Individuals who require services, like older people and people with disabilities, can be vulnerable to intruders and must have good security in their homes. However, it is also important that the person is able to easily leave their home in the event of a fire or other incident, and that others are able to get into the house should the person require emergency assistance.

When assessing security, check that:

▶ the home has deadlocks on doors and windows

▶ locks on doors can be easily opened from the inside without a key

▶ there is appropriate security lighting at entries and exits to the home

▶ there is a locked key box that workers or emergency services can access

▶ swimming pools have appropriate fencing and self-locking gates

▶ the person has access to personal security alarms if they require urgent assistance.

Infection risks

There can be many reasons why a person may be at risk of infection, or may put others at risk of infection, in the processes of personal care. A person may have a condition that causes a decreased immunity to infections, or they may carry an infection or disease that is easily transmitted to others. There may be dirt, mould or other areas where bacteria and infectious organisms can grow within the home that can put people at risk. When performing an environmental risk assessment, consider the risks for infection described below.

Risks for infection
Appropriate waste management should be in place, particularly for items that may be soiled, such as continence pads or dressings.
Workers should have access to gloves and other personal protective clothing for performing personal care tasks.
Areas that are constantly damp may have mould or bacteria growing.
Homes should have adequate heating and cooling to assist in preventing infection.

Physical risks

There are a variety of issues, including weight and behaviours, which need to be considered when conducting a risk assessment for a person. If the person experiences sudden or unexpected changes in health, including the loss of vision, hearing or balance, these can signal serious medical conditions, so seek immediate medical attention to ensure the individual plan is adapted to include appropriate treatment.

Consider the following issues during your assessment of the person	
▶ Weight	▶ Behaviours of concern
▶ Skin integrity	▶ Impaired judgment
▶ Infection	▶ Impaired cognition
▶ Self-neglect	

Weight

Overweight individuals may have difficulty bearing their weight independently when performing tasks such as transferring into showers, and may need support. Workers providing support must be aware of their own safety in assisting these individuals to transfer and weight bear. Most workplaces have a 'no lift' policy, meaning workers are not permitted to lift a person physically at all, and must use lifting equipment. Ensure equipment is appropriate for the person's weight and is safe for a worker to use with heavier individuals. The person's weight should be regularly monitored and managed to ensure that risks are still identified and handled.

Individuals who are underweight may have risks associated with personal care, such as bones that fracture easily or thin skin. Their weight may need to be monitored to ensure it is managed and does not put their health at risk.

Skin integrity

Older people and some people with disabilities may have thinner skin. This means their skin may tear easily if knocked or scraped. It is important that this risk is identified and personal care provided to manage this risk. These individuals may also be susceptible to infection if they have sores or wounds, and must be checked for lesions to ensure this risk is managed. A person with poor circulation or diabetes can also be at high risk of infection from breaks or cracks in their skin.

Infection

A person may have a condition that affects their immunity to disease and infection. Infection may be internal, such as in the lungs or kidneys, or external through breaks in the skin. Be aware of the conditions that may cause a person to be more susceptible to infections and ensure that appropriate methods are used to prevent or minimise their exposure to bacteria and germs. Where a person has poor immunity, it may be necessary to ensure that workers have not been in contact with viruses or infections, that appropriate protective clothing is used and that waste is disposed of appropriately. It may also be necessary to monitor the person's temperature and skin to ensure any signs of infection are detected early and managed.

Self-neglect

People who are old and frail or who have disabilities or mental health issues may find caring for themselves difficult. However, even with support, a person may neglect their self-care, health and safety, despite having the skills and abilities to complete these tasks. Look for signs that the person is neglecting their self-care or that this may occur.

Signs can include when a person does not:

▶ eat or drink even when meals and drinks are prepared for them

▶ maintain their personal hygiene or appearance

▶ participate in social or family activities

▶ keep themselves safe; for example, locking doors.

Behaviours of concern

Individuals who display behaviours of concern may pose a risk to themselves or others. Behaviours of concern include:

▶ physical or verbal aggression

▶ inappropriate sexual behaviour

▶ self-mutilation or abuse

▶ eating or drinking dangerous substances.

Identify the risks of a person displaying behaviours of concern and ensure steps are taken to minimise or manage these behaviours and their impact on the person and others. Always report signs to your supervisor. Talk with more-experienced people to see how they manage these individuals.

Impaired judgment

Individuals with intellectual or cognitive disabilities may have difficulty deciding the best or safest way to perform a task. They may put themselves or others at risk of harm or injury by making an inappropriate decision about how to act or perform a task. Here are some examples:

▶ Not knowing how to safely protect money or valuable goods

▶ Not knowing who to trust with their safety or approaching strangers

▶ Believing they can perform tasks or use equipment, such as electrical appliances, tools and cars, safely

Be aware of conditions or disabilities that can affect the person's ability to judge situations and solve problems appropriately, and identify risks associated with impairments of this type so they can be appropriately managed.

Impaired cognitive functioning

Some conditions and disabilities may affect the person's memory and thinking. Where this is the case, the person may be at risk of placing themselves in a dangerous situation. Individuals with memory problems may turn on an appliance and forget about it, go out of the home and become lost, or forget to perform personal care and other tasks. Individuals with other cognitive impairments may be unable to think clearly through a situation, may become inappropriately afraid or untrusting of others, or be overly friendly and trusting of strangers.

Be aware of situations where a person may have impaired memory or thinking, and consider the risks this is likely to pose to their health and wellbeing, and that of others around them.

Types of abuse and neglect

Abuse happens when a person is deliberately hurt or harmed, or their environment is neglected. There are many forms of abuse; abuse can be physical, financial, or emotional. Read the progress notes that support workers have written, have regular meetings with the care team and ensure ongoing and clear communication with family members, carers and significant others. Make sure you ask for training to recognise specific signs of abuse or neglect, which are described below.

Physical abuse

Physical abuse may include:

▶ hitting, pushing, slapping and shoving

▶ leaving the person in pain, or unattended when they have been incontinent

▶ inappropriate restraint, including using drugs to sedate a person

▶ not providing enough food or drink

▶ sexual abuse.

Signs include:

▶ unexplained bruises, marks or swelling, bleeding

▶ broken bone/fractures, or broken possessions

▶ weight change, especially weight loss

▶ malnutrition, dehydration or loss of fluid, or constant infections.

Sexual abuse signs include:

▶ increasing withdrawal or depression

▶ difficulty walking or sitting

▶ genital bruising, bleeding or discharge

▶ pulling away when receiving physical care.

Financial abuse

Financial abuse is when a person's money is taken from them or used in a way that is not helpful to them. Examples include:

► controlling a person's goods or possessions

► withholding/denying a person access to their money

► forcing a person to change their will.

Signs include:

► inability to pay bills; having insufficient funds to meet everyday expenses

► unexplained bank withdrawals

► unusual signatures on banking documents

► disappearance of goods and possessions

► having their money spent in ways that are not supportive or beneficial to them

► becoming increasingly withdrawn

► seeming afraid of another person.

Emotional abuse

Emotional abuse affects a person's feelings and can make them feel afraid or worried about being isolated or hurt. Examples include:

► bullying, threatening and harassing

► belittling the person

► isolating the person

► not respecting the person's customs or cultures

► not listening to or respecting a person's choices.

Signs include:

► unexplained distress

► fear

► lethargy

► lack of grooming

► increasing withdrawal

► mental confusion.

Neglect

Neglect is when a person is not provided the care and support they are entitled to. Examples include ignoring hygiene, nutritional and comfort requirements, such as:

▶ no aids or support provided to assist the person

▶ providing insufficient food

▶ leaving grooming unattended

▶ not being given appropriate medication when needed

▶ leaving injuries unattended

▶ not supervising the person.

Be observant and look for signs of:

▶ unkempt appearance

▶ weight loss

▶ withdrawal

▶ pale appearance

▶ malnourishment (hungry) or dehydration (thirsty).

Deal with potential neglect and abuse

The first thing you must do when you identify other risks to a person, is document and report the risks. It is critical that these risks are reported immediately to reduce the likelihood of harm, and for strategies to be put in place to minimise or remove their impact in the future. Consider changing the individual plan so the person and their carers can work on overcoming issues that present an immediate risk.

Most organisations have a risk report form that must be completed when risks are identified. Where the possibility of the risk causing harm or injury is immediate, coordinators and workers should ensure the risk is also reported verbally – by phone or face to face.

A risk report form requires information such as:

▶ date, time and location

▶ the names of those involved

▶ a description of the identified risk

▶ a description of any immediate action taken to prevent harm or injury

▶ who the risk has been reported to

▶ how the risk information will be followed up.

Physiological risks

You will need to consider physiological risks that a person may be exposed to. This includes the risk of injury, perhaps from falling or from risk taking behaviour like drug use or sexual activity. Physiological risks also include risks to health from poor nutrition or loss of muscle mass due to inactivity. You will need to evaluate what might be impacting on a person's physiological health and minimise this risk by encouraging behaviour changes such as improved nutrition, regular exercise, reducing or eliminating risk-taking behaviour or putting in place precautions such as using condoms or learning first aid.

Discuss risks with the person

All activities have some degree of risk. There are also risks associated with preventing a person from participating in activities. In particular, a person may miss out on opportunities to maintain and build their skills and improve their health and wellbeing. A person has a right to make informed choices about the activities that are included in their individual plan. A person who understands the risks associated with different activities is in a better position to evaluate whether the potential benefits of an activity outweigh the risks, and to take steps to reduce or remove the risks.

Effectively communicate potential risks

Some individuals may have difficulty understanding the risks that are being explained, or may have little or no insight into these risks. People with an intellectual disability may not immediately recognise risks. Likewise, people with an acquired brain injury or mental illness may have impaired judgment. People's ability to recognise risk can also be related to age. For example, it is likely that the brains of teenagers or young adults have not fully matured and they may underestimate the likelihood of potential risks and consequences. It is therefore important to include the person's carer, family member or another advocate or interpreter in your discussion; this ensures that everyone understands the risks and their consequences and strategies are put into place to minimise them.

Explain consequences

Workers should talk about the possible consequences if the risk is not properly managed and explain that, while services do their best to minimise risks, many are difficult to remove altogether and incidents can still occur. The following information describes example situations that may cause a risk and the possible consequences if the risk is not managed.

Mould

Risk: Bacteria could grow in the damp areas. The ceiling could fall if it becomes very wet.

Consequences: Illness or injury to the person or others.

Room

Risk: The worker may not be able to get to the person easily to provide support/ assistance.

Consequence: The worker could injure their back or injure the person.

Stairs

Risk: The person could fall when using the steps.

Consequence: Injury to the person.

Gastroenteritis

Risk: Cross-infection to other residents and staff.

Consequences: Widespread illness in the facility and possible death of frailer residents.

Diet

Risk: The person could become malnourished.

Consequence: The person could become seriously ill or die.

Violence

Risk: The person could injure a worker or other person.

Consequences: Injuries and potential admission to a specialised facility.

Memory problems

Risk: The person may leave appliances switched on or wander away from the home.

Consequences: The person may become injured or lost.

Duty of care

Community services organisations and workers have a responsibility to provide a duty of care to ensure the safety and wellbeing of people in receipt of their services. Legislative and regulatory obligations underpin an organisation's policies, which determine the procedures to guide service delivery. Here is more information about duty of care.

Duty of care

Duty of care is the obligation a person has to act in a way that would not cause harm.

Negligence

Negligence occurs when duty of care has been breached and harm to either person or property ensues. It is the legal and ethical obligation of any community worker, supervisor or organisation to ensure that people using services are not exposed to unnecessary or unreasonable risk.

Dignity of risk

The rights of people to dignity and choice, upheld in legislation and service standards, also require that duty of care or safety is not used as a reason to limit a person's freedom or personal choice. A support worker's adherence to duty of care and safety must be coupled with the concept of dignity of risk, which means that a person has the right to make their own choices and to take risks.

Safety and security

When selecting strategies, you need to keep in mind work health and safety legislation, industry standards and your organisation's policies and procedures. The requirements for complying with law, guidelines, regulations, standard and organisational policies and procedures are discussed below.

Work Health and Safety

▶ The *Work Health and Safety Act 2011* (Cth) regulates work health and safety (WHS) for the Commonwealth. It specifically aims to protect people in workplaces from risk to their health or safety and to promote safe and healthy work environments. All states and territories except Victoria and Western Australia have harmonised with this Act; these states continue to enforce state legislation for occupational health and safety.

Codes of practice and industry guides

▶ Codes of practice and advisory standards provide practical guidance that should be followed. These cover areas such as manual handling, managing hazardous substances, controlling infectious diseases and occupational overuse syndrome.

▶ A range of guidelines are also available in each state and territory from the relevant statutory body for health and safety (for example, WorkSafe Victoria). These generally address specific hazards and provide assistance to meet the requirements of the relevant legislation, regulations and codes of practice.

Government program standards

▶ Each government-funded aged, disability, mental health or community support program has quality and safety standards they must meet. These standards relate to the legislation governing the ways in which services must be delivered: the *Aged Care Act 1997* (Cth), the state and territory disability Acts, the state and territory mental health acts and the *Home and Community Care Act 1985* (Cth). Services are assessed on a regular basis against these standards and must meet or exceed them. Those found to not meet standards may have sanctions (limitations to services) placed on them or may lose their government funding.

Organisational policies & procedures

▶ Organisations base their policies and procedures on legislation, so if you follow them you are following the requirements. For example, if you identified a potential risk of a person slipping, tripping or falling, check your organisation's policy to make sure your solution is safe, appropriate and in line with designated protocol.

Example

Conduct risk assessment specific to the person's circumstances

Elspeth is a coordinator in aged care. One of her tasks is to do a home risk assessment for a new person who will receive services. After she has completed this, she discusses the outcomes with the person, Mr Simic.

She begins by explaining that her service is committed to ensuring that care and support is delivered in the safest way possible. She says the care plan is developed to minimise the risks that Mr Simic, a worker or others may be injured or harmed. She explains that his safety and wellbeing, as well as that of the workers delivering the support, is very important.

Elspeth points out the stacks of newspapers in the hallway and the amount of furniture in the lounge. Mr Simic says he has always lived like this and cannot see the problem. Elspeth explains to him that the workers need to be sure they can move easily around the home. She also explains that he is at risk of tripping over the papers or knocking himself on the furniture.

Elspeth also points out that the floor in the bathroom has some cracked and missing tiles. She explains that these pose a risk of tripping him or a worker over, and also of harbouring dirt and germs that could make him sick.

Elspeth talks to him about the trees in the front yard that overhang the pathway to the front door. She explains that low branches could cause him or others an injury.

Practice task 14

1. List some of the possible locations where a person may be at risk of harm.

2. Explain what is meant by duty of care for a worker.

Click to complete Practice task 14

3F Manage any conflict or differences with regard for the person's perspective

Most people involved in the planning process want to achieve the best possible outcomes for the person. However, this does not mean they agree on how these outcomes should be achieved. There may be disagreement about the limits of the service you can provide, ideas about what is in the person's best interest, how to achieve the person's goals and the specific strategies selected. Whatever the cause and nature of the conflict, you must continue to keep the person in focus and deal with the conflict. Always consider what is in the best interest of the person.

Benefits of conflict

Conflict is often seen as negative. When managed appropriately, conflict can help you develop better plans. In some groups, people focus on agreeing with one another. They may do this in an attempt to be courteous, or they may not have the confidence in their own ideas. This often occurs in groups where there is a dominant idea. This means people do not voice concerns about ideas. It also means people may be afraid to offer up alternative ideas. In these cases, you may miss out on building a comprehensive picture of the person's needs and may overlook issues that could prevent them from achieving the goals.

Handle conflict

How you handle conflict depends on your personality and your way of coping. Ignoring the conflict, reacting aggressively and being assertive are the three main ways of handling conflict. These are presented below.

Ignore the conflict

This approach is also known as a passive approach. Rarely does the problem get better or resolve itself. There comes a point where you need to respond to conflict. If you do not take a proactive approach, it is likely that the conflict will escalate.

React aggressively

Conflict can trigger a flight or fight response. A passive person will flee from conflict, whereas an aggressive person becomes defensive and verbally attacks the initiator of conflict. Like a passive approach, an aggressive approach may cause the conflict to escalate. An aggressive approach causes the conflict to escalate much more quickly than a passive approach.

Take assertive approach

An assertive person manages conflict in a manner that is respectful of the rights of all people involved. Conflict can be stressful to watch. It can be even more stressful if someone is openly hostile towards you. You can learn to be assertive. Acknowledge the person's feelings. Let them know you understand they feel frustrated, angry or upset. Present your side using 'I' statements. To defuse the conflict, stay calm, keep the volume of your voice low and speak slowly. If you raise your voice, the other person will raise their voice. If this continues, you both end up speaking louder and louder at one another.

Example

Manage any conflict or differences with regard for the person's perspective

Jessica is working with Mrs Reynolds and her son, Frank. Frank says, 'You're all the same. You're all more interested in filling out forms than worrying about Mum.'

Jessica responds by saying, 'I know the process can be frustrating, but these forms help make sure that the care is appropriate to your mum's needs.'

Frank snarls, 'Whatever. It's not like you're going to do anything.'

Jessica takes a deep breath to calm herself down. She then says, 'Frank, it sounds like you may have had some negative experiences. If you can help me develop a plan of action for your mum, I will give you a copy. I can also give you my business card. Please call me if you have any concerns. I cannot always get to the telephone straight away, but I usually return calls within 24 hours.'

Frank uncrosses his arms and leans forward. 'All right, tell me what I have to do.'

In this situation, Jessica handles Frank's hostility in a positive manner. She responds to his concerns, but does not dwell on them. She also gives her details to Frank to demonstrate her commitment. By providing Frank with information about her availability to answer telephone calls, she also eliminates the possibility that he becomes angry if she is unable to answer his calls immediately.

Practice task 15

1. Explain how conflict can be productive.

2. Describe the three main ways to manage conflict and identify the most effective approach.

Summary

1. To develop an effective plan you need to respect the person's perspective, foster their strengths and capacities, and promote their participation.

2. There are a variety of useful planning tools you can use based on the needs of the individual.

3. By identifying and confirming key aspects of individualised service delivery in collaboration with the person and other stakeholders you can establish effective goals.

4. Consider interrelated needs of the person and plan an integrated approach to service delivery.

5. You will need to conduct risk assessments specific to the person's circumstances, discuss with the person and work collaboratively to minimise risk.

6. Conflict is not always negative, it depends on how you manage it.

Learning checkpoint 3
Plan service delivery

This learning checkpoint allows you to review your skills and knowledge in planning service delivery.

Part A

1. How can a strengths-based approach in planning service delivery support workers to respect the perspective of the individuals they work with, foster their strengths and capacities, and promote their participation?

2. When might it be more appropriate to use a structured planning process rather than a person-centred process, such as MAPS or PATHS?

3. What are three factors you should consider when working collaboratively to establish motivational goals?

....

....

4. List three types of resources that might be necessary in individualised service delivery.

....

....

....

5. Name three supports a person may need when transitioning to a new service provider or exiting a service.

....

....

....

....

....

6. What are the requirements of integrated service delivery?

....

....

....

....

....

....

....

....

....

....

Part B

Read the case study, then answer the questions that follow.

Roger is approaching his 80th birthday and lives at home with his two cats. Molly has been asked to complete a risk assessment for Roger.

1. Describe the signs that Molly should look for that may indicate that Roger is at risk?

2. Molly notices that Roger's home has untidy piles of newspapers on the floor in every room. What risk management strategies should Molly consider? What should Molly do if Roger disagrees with her risk assessment?

3. Molly also notices that Roger is very thin. Why could his weight be a concern?

4. What communication skills might Molly need to work collaboratively with Roger?

5. What is Molly's duty of care to Roger?

Topic 4

In this topic you will learn how to:

4A Consult with relevant people to assess the quality of, and satisfaction with, service

4B Address and report on any problems with the quality of, or satisfaction with, service delivery within organisation procedures

4C Work with the person and others, to identify and respond to the need for adjustments to individualised plans and support the person's self-determination

4D Identify areas for improvement to overall service delivery implementation of organisation

Review service delivery implementation

By this stage, you and others will have spent a great deal of energy developing an individual plan. Unless you ensure all resources are available to regularly monitor the implementation of the plan, your efforts may be wasted. Once the plan has been implemented, you should continue to monitor whether or not the plan remains appropriate to the person's needs and is supporting their self-determination. This review process will help you and others make timely adjustments to the plan.

4A Consult with relevant people to assess the quality of, and satisfaction with, service

A person's individual plan should be a working document, meaning that the plan should be referred to and used on a regular basis. You must let the person, family members and carers know that they should tell you if they are not happy with any part of the plan. There could be many reasons for this; for example, the activity is proving too costly or their condition has deteriorated. Tell them it is also useful to let you know if the plan is working well. This is just as important to know so activities can be continued or extended. You need to actively seek their feedback and input.

Consult with relevant people

You should consult with all relevant stakeholders to identify areas of the plan that are working well, and issues that have arisen. Feedback from a range of sources can be very useful to clarify how the plan's implementation is working. Family members, friends, advocates, healthcare workers, other health professionals and, most importantly, the person being supported, can all provide input. Encouraging feedback from a variety of people enables you to develop a comprehensive picture of the situation. Feedback can be delivered verbally or in written form. All letters, emails and responses from questionnaires should be read, responded to in a timely manner, acted on and filed. When conducting surveys or questioning the person, clarify the areas of concern with the person to establish whether the problem relates to the activities in, or the implementation of, the care plan. The sooner you get feedback, the sooner you will be able to amend the plan.

Assess the quality of service delivery

Ask family members, carers, and significant others to watch the person as they undertake activities specified in their plan. Tell them what to look for, such as the person's enjoyment, the ease with which they carry out tasks and any difficulties they are having. Facial expressions and body language are important to take note of, especially in people who have difficulty speaking. They should let you know what they observe on a regular basis and you should include this in the person's case notes.

You may specifically request a person to demonstrate a task to ensure that it is appropriate. Encourage the person to discuss any activities or parts of the plan they are not enjoying or finding too difficult. Let them know that the plan can be changed if any aspect of the plan that is not working, so it is useful for them to discuss issues with you. Similarly, ask them to tell you what parts of the plan are working well.

Assess satisfaction with service delivery

It is important to assess a person's satisfaction with the services they are receiving. If a person is not satisfied, they may not participate actively in service delivery, or

may refuse services. You can assess a person's satisfaction with the services they are being provided with using a variety of methods. Once you have established a trusting working relationship with the person, you may be able to directly ask them for feedback and discuss any issues openly.

Below are some of the feedback tools you could also consider using.

Questionnaires

A questionnaire is a set of questions that you ask a person to respond to that gathers data. They can be written or verbal.

Surveys

Surveys are a process to gather data which could include a questionnaire, but also may include observation or measurements of outcomes. You may ask the person about their satisfaction, but also observe their enjoyment of activities or measure their progress.

Plan review

Many organisations have a document that you can use to review the plan formally. This allows you to assess progress and improve service delivery.

Example

Consult with relevant people to assess the quality of, and satisfaction with, service

Mrs Cucevic has been receiving services for three months. Her support worker has asked her to complete a questionnaire to gain feedback regarding her satisfaction with service delivery. The feedback form can be seen below.

FEEDBACK FORM

Name: Maria Cucevic

Date: 23/01/2016

Tick the statements below that you feel reflect your experience with our service

☐ I was asked about my needs and preferences before the service plan was developed.

☐ All of my needs were considered.

☐ My personal care needs are met.

☐ My safety and security needs are met.

☐ My need to spend time with others is met.

☐ I am treated with dignity and respect by all staff.

☐ I receive the information I need about meeting my personal care needs.

☐ Staff provide me with good advice about meeting my needs.

☐ My needs are regularly reviewed.

☐ I am able to easily communicate with coordination staff about changes in my needs.

☐ Services and risks have been clearly explained to me.

Practice task 16

1. Who are the potential sources of feedback regarding the effectiveness of the plan in service delivery?

2. Describe the ways one can assess whether service delivery is effective.

Click to complete Practice task 16

4B Address and report on any problems with the quality of, or satisfaction with, service delivery within organisation procedures

If you become aware of any problems with the quality of service delivery, either through observation or from feedback from stakeholders or the person, it is important that you address these issues immediately to ensure the person is receiving the support they require. Likewise, if a person or stakeholder indicates that they are not satisfied with the service delivery, you should discuss any concerns and seek to address them as soon as possible. Your organisation will have procedures to report and respond to identified issues, which you would follow when addressing them.

Address problems

You need to have a clear understanding of what the problem with service delivery is before you can address it. Decide whether the issue is with the service delivery plan or with the quality of service delivery. The most important thing is that any concerns are addressed as soon as possible and that the person, and any relevant stakeholders, is included in discussions regarding how the problem will be resolved. This may include changing the service delivery plan to better meet support needs, improving the quality of service delivery by providing additional training to staff or requesting additional feedback from the person to improve their satisfaction with service delivery.

Below are some questions to consider when addressing problems.

Questions to consider when addressing problems
▶ Have the person's circumstances changed?
▶ Does the service delivery plan need to be amended to meet support needs?
▶ Is there an issue with staff knowledge or skills that needs to be addressed?
▶ Are the activities or tasks in the service delivery plan too difficult or not enjoyable for the person?
▶ Are additional resources required to improve service delivery?

Report on problems

Your organisation will have a process to report on any problems a person may be experiencing with the quality of service delivery, or their satisfaction with it. This may include adding a file note to the person's case file detailing the problem and how it will be addressed. You may be required to report to a supervisor, and your organisation may have a document for you to complete to report the problem and how it will be addressed. It is important you follow organisational procedures so problems are addressed as soon as possible.

Organisation procedures

Most organisations have a complaints procedure that you should follow to manage and report any problems associated with the quality of, or satisfaction with, service delivery. Below is an example of a complaints process.

Complaints process
Have the person clearly identify their complaint. This should be recorded appropriately.
Assess the complaint – gather and evaluate relevant information to assess the validity of the complaint.
Determine an appropriate course of action to address the complaint.
Inform the person of any action that is taken to address the complaint.

Example

Address and report on any problems with the quality of, or satisfaction with, service delivery within organisation procedures

Roberto observes Craig preparing an evening meal for himself. Roberto notices that Craig has difficulty using some of the kitchen utensils and almost cuts himself on one occasion. Roberto also notices that Craig is swearing and clearly not enjoying the process.

Roberto discusses what he has observed with Craig and Craig agrees that he is struggling with the food preparation goals on his service delivery plan. Roberto suggests to Craig that perhaps he needs different resources to make the task easier. Roberto makes a note on Craig's file and discusses his concerns with his supervisor. Roberto makes an appointment for Craig and himself to visit an independent living expert to learn what kitchen aids are available that could support Craig's goals.

Practice task 17

1. What is the most important thing when addressing problems with service delivery?

2. Describe how a service delivery problem could be reported.

Click to complete Practice task 17

4C Work with the person and others, to identify and respond to the need for adjustments to individualised plans and support the person's self-determination

As soon as changes are identified, service delivery plans must be adjusted to improve outcomes for individuals and prevent further complications. Procedures for adapting service delivery plans may change between organisations. It is important to consult with the person, their advocate, or their family to find out about their preferences. It is equally important to seek advice, where relevant, from healthcare professionals to find out about best practice for treating the person's disease, illness or condition, to investigate and avoid possible adverse effects, to find likely outcomes and to identify new goals. Remember, it is the person's right to refuse the service.

Identify need for adjustments

The need for adjustments to the service delivery plan can be identified by observing the person engaging in activities or tasks outlined in the plan. They can be identified by discussing how the plan is going with the person and other stakeholders, such as their family or healthcare professionals or other service providers. Keep in mind that the person's circumstances can change, so while the plan may have been effective previously it now needs adjustment. For example, the person may have a change in living arrangements or location, they may have relationships start or end, they may begin or cease employment, they may recover from an illness or injury, they may become less well. All of this can change the type and level of support a person requires, meaning changes to the service delivery plan if necessary.

Types of adjustments

There are a number of things you may do to change a person's plan, including offering additional services or referring the person to another service provider. Presented below are changes that may be made, with examples for each.

Additional services

You may need to offer additional services. For example, Leigh has been receiving home help for the last 12 months. Recently he has been struggling with his personal care requirements. A personal care worker is employed to assist Leigh with his activities of daily living.

Modify services

You may need to modify the current services. For example, Cheryl has been receiving one-to-one counselling for depression. This service is modified to include group counselling and peer support.

Different services

You may need to offer different services. For example, Jo has been participating in a walking group. Now that it is winter, she finds it too cold to exercise outside. She attends water aerobics instead. Her need for companionship and exercise are still met but in a different way.

Different provider

You may need to utilise a different service provider. For example, Keith is unhappy with his current dietitian. He feels he does not listen to him. An alternative provider with a good record of meeting the needs of older people is selected.

Change the individualised plan

When a person or their advocate is happy with the new arrangements, the details must be recorded according to the organisation's procedures. Like all inclusions in the individual plan, the expected outcomes must be clear, along with who is responsible for implementing the strategy. These changes must be clearly communicated to all people responsible for implementing and monitoring the plan.

Here is an example procedure for changing an individual plan.

Procedure for amending individual plans

1. Seek feedback from the person.

2. Research alternatives.

3. Brainstorm alternatives with the person.

4. Complete a draft of the changes.

5. Discuss the draft with the person and their advocate or significant others.

6. Formalise the new individual plan.

7. Implement the new individual plan.

8. Monitor and review the new individual plan.

9. Make further adjustments if required.

Self-determination

Self-determination refers to the right of individuals to have full power over their lives and to be able to make independent choices about decisions that affect them. Each individual receiving service is an expert in their own needs. It is essential all workers acknowledge and work with the expertise of each person and their advocates where appropriate; this may have an impact on the quality and responsiveness of services being provided. If the person's expertise is not acknowledged, they may feel disempowered; services and responses may be too interventionist; and important information about the person's needs may be overlooked.

Support the person's self-determination

The role of community service workers or coordinators working with any person requiring services is that of facilitator, supporting and assisting the person to make decisions about their individualised plan and the services they receive. There are a number of tools and strategies you can use in order to work in a way that supports self-determination and draws on the expertise of individuals. Presented below are the four commonly used and effective approaches that you can use.

Provide accessible communication channels and information

You must ensure communication and information is accessible for the person you are working with. Consider providing information in other languages, planning for extra time, using interpreters (spoken or sign language), familiarising yourself with various communication aids, and using and providing information in plain English or visually when appropriate. Each individual must be fully informed of all available options for their care and the likely outcomes of any decision.

Work with and support advocates

Some older people, people with disabilities or people with mental health issues may have an advocate to represent their needs and rights. An advocate may be formal or informal, paid or unpaid. If an advocate has been appointed, the support worker must acknowledge the advocate's voice as being representative of the person. You may also need to provide information to individuals about advocacy services and how to access an advocate.

Commit to maintaining privacy

Ask individuals who they would like involved in decision-making processes and planning. No-one should provide information to other people, even close family or partners, without the consent of the person or their appointed spokesperson or advocate. Some individuals may be unable to make independent choices if they do not feel comfortable with who is present or if they are forced to discuss private matters in front of certain people.

Respond to individual needs

Ensure all planning processes and discussions around decision-making are presented in a way that responds to the individual needs of the person you are working with. Consider the individual's comfort based on their age, disability or health needs. Consider where discussions are held and the time of day. Find out if there are any cultural needs and be aware of and be responsive to these. Ensure all processes are meaningful and accessible to the person who is using the services.

Example

Support self-determination

Anna is a care coordinator working with Frank, who is 58. He has an acquired brain injury as a result of a motor vehicle accident and has been given a compensation payout of $200,000. Anna asks him about his plans.

Frank says, 'I've always wanted a BMW, so I'll buy one of those.'

Anna says, 'How much is a BMW?'

Frank answers, 'About $65,000.'

Anna replies, '$65,000? So that will leave you with about $135,000. Then what?'

Frank shrugs. Anna then asks, 'Why don't we look at how long the money will last?'

Anna and Frank then calculate Frank's basic living expenses, which total $24,885 per year.

Frank looks at the calculations and says, 'The money isn't going to last long is it?'

Anna answers, 'Not unless you plan ahead. Are you interested in seeing a financial counsellor? They may be able to help you gain the greatest value for your money.'

In this situation Anna supported Frank's right to self-determination by drawing his attention to important facts, but providing him with the time and space to make his own decisions.

Strategies to support workers

There are a range of strategies that can support workers to provide person-centred care, including those listed below.

Strategies for supporting a person-centred approach
▶ Demonstrate a person-centred approach in all interactions, and model the appropriate self-determination approach to other workers.
▶ Pair workers with experienced colleagues who have demonstrated their ability to support individual's self-determination.
▶ Run formal training sessions to assist new workers. Use experienced practitioners and experts to talk about their experiences.
▶ Engage the services of disability, mental health and aged care advocates who can explain the importance of self-determination.
▶ Conduct staff meetings where staff share ideas about promoting self-determination.
▶ Ask for feedback from individuals about whether they feel they are listened to during care plan development.

Example

Work with the person to identify and respond to the need for adjustments to individualised plans

David has recently undergone cataract surgery. He received support from the district nurse and a personal care worker to carry out his activities of daily living for the first 48 hours after his surgery. David's sister rings the hospital four days after his discharge from hospital to report that David's vision has not improved, and that he is struggling with his personal care tasks.

The hospital contacts the aged care assessment team and they meet with David. David is referred to the council's Commonwealth Home Support Programme (CHSP) team. The CHSP team's coordinator visits David within 24 hours of referral and works with David, his sister and the district nurse to develop a plan to assist David with his activities of daily living. These changes are documented in the service delivery plan. The service delivery plan is also made available to the personal care assistants assigned to David's care.

David's condition will be monitored to see whether further adjustments to his care plan are necessary.

Practice task 18

1. List the approaches to support self-determination.

2. Describe the types of adjustments you may need to make to a person's service delivery plan.

Click to complete Practice task 18

4D Identify areas for improvement to overall service delivery implementation of organisation

Sometimes the feedback from people receiving services and your own observations, will identify systemic problems with service delivery in your organisation. You may notice patterns where individuals commonly indicate dissatisfaction with a particular component of service delivery, or you may identify that a number of individuals are not making progress in their service delivery plans in one particular area. You may simply notice that the feedback mechanisms for people receiving services are not consistent or have not been put in place.

Identify areas of improvement

It is important to evaluate the existing implementation strategies of your organisation to identify what you are doing well, and where there is a need for improvement to service delivery. This can ensure that service delivery meets best practice standards, and can help manage any problems before they impact negatively on the organisation and people accessing the services.

Evaluating services provides you with an opportunity to gain feedback from stakeholders who come in contact with your organisation. This can be people receiving services, their families and significant others, and other service providers.

Key factors for effective service delivery

There are a number of key factors to effective service delivery, which provide you with a starting point to identify areas for improvement. You, and your organisation, can consider each of these factors in terms of how well the organisation performs. Below are some of these key factors.

Cultural awareness

▶ In order to provide quality service delivery, organisations need to ensure that cultural diversity is considered in implementation of services. Are all staff trained in cultural awareness? Are there staff members from diverse cultures in the organisation? Do staff have access to interpreter services and translated resources? Does the organisation have a reconciliation action plan in place? Is the organisation welcoming to diverse people?

Strengths-based approach

▶ Consider whether the organisation is truly providing strengths-based services to individuals. Is there still a focus on deficits and problems of individuals receiving services? Are individuals encouraged to identify and build on strengths?

Privacy and confidentiality

▶ Does the organisation meet legislative and industry standards to protect the individual's privacy and provide them with confidential services?

Person-centred approach

▶ Does the organisation put the focus on the person receiving services? Does the organisation support self-determination and provide the person opportunities to grow through taking managed risks?

Barriers to effective service delivery

While evaluating existing services, you are likely to come across barriers to effective service delivery.

Barriers to effective service include:

▶ staffing barriers, such as limitations in skills, experience or knowledge

▶ funding barriers, such as insufficient funding to provide quality services or adequate staffing levels

▶ organisational culture barriers, including an inflexible culture or structure

▶ strategic planning barriers, including overly ambitious plans or plans that do not meet needs of target group

▶ partnership barriers, such as collaborating without identifying common purposes, communication challenging or different visions.

Example

Identify areas for improvement to overall service delivery implementation of organisation

Ferndale mental health services engage a consultant to review and evaluate their service delivery. The consultant talks to staff, management, individuals receiving services, and other stakeholders, such as family members and other service providers.

The consultant identifies the organisation's strengths as providing person-centred services to individuals that focus on strengths and support for self-determination. The consultant also identifies that the organisation has a culture of providing excellent services to people from diverse cultural backgrounds, and employing Indigenous Australians and culturally and linguistically diverse staff. The consultant notes, however, that family members of those receiving services are not satisfied with all of the organisation's services. Family members do not feel included in the planning and implementation of services, and do not feel valued or informed. Ferndale immediately begins planning for more family-inclusive services, and provides training for staff to engage with family members.

Practice task 19

1. How you would know whether an organisation is providing culturally appropriate services?

2. List the potential barriers to effective service delivery.

Click to complete Practice task 19

Summary

1. Consult with individuals receiving services and other stakeholders to assess the quality of, and satisfaction with, service delivery.

2. Report and address any problems with service delivery as soon as possible.

3. Work with all stakeholders to identify and adjust individualised plans to meet needs.

4. Support the person's self-determination in making adjustments to service delivery plans.

5. Identify areas for improvement to the service delivery of the organisation.

Learning checkpoint 4
Review service delivery implementation

This learning checkpoint allows you to review your skills and knowledge in reviewing service delivery implementation.

Part A

1. List the people you might consult with regarding the quality of, and satisfaction with, service delivery.

2. Explain the types of adjustments you may need to make to a person's individualised plan.

3. Describe what self-determination means.

4. What could the barriers to effective service delivery include?

Part B

Read the case study, then answer the questions that follow.

1. What should Bevan consider when addressing this feedback?

2. How could Bevan report this issue?

Topic 5

In this topic you will learn how to:

5A Clearly record planning activities and decisions made, and prepare reports and other documentation correctly

5B Maintain currency of documentation by making appropriate updates

5C Incorporate review findings into continuous improvement processes

Complete reporting requirements

Documentation of service delivery plans, case notes, and reports is likely to be part of your role. Current information documented accurately assists in providing quality service delivery, ensures that the needs of people are met appropriately and assists in continuously improving organisational processes.

5A Clearly record planning activities and decisions made, and prepare reports and other documentation correctly

You should always record details from the planning meeting, as well as the individual care plan that arises from the meeting. This information can be used by other workers, supervisors and health care providers to see what occurred during the planning session, how the person was involved in decision-making, why the goals were selected and the activities and strategies selected. Not only can this information be used to see what has happened, it can also be used to assess what must happen in the future. In particular, stakeholders can identify and fulfil their responsibilities. You may also be required to prepare reports of various kinds including risk assessments, service data or incident reports. Your organisation will have procedures and requirements regarding reporting.

Accurate and up-to-date record keeping underpins quality service provision that meets the specific needs of individuals receiving services. Actions are documented in a way that increases accountability and duty of care. Record keeping needs to adhere to legislative requirements, policy requirements and any organisational protocols. Completing documentation, reporting and storing material is an essential role of support workers and coordinators to enable a person's care information to be shared.

Your manager, senior management and auditors can refer to the documentation recorded to make sure your organisation is providing the sorts of services expected under relevant legislation and standards.

Clearly record planning activities and decisions made

During the planning process, you must make sure everything that happens at the meeting is recorded clearly following your organisation's procedures. These records should include details about the topics discussed, the points and issues raised by each stakeholder, as well as the strategies developed. They can be used to make sure planned action is taken, and can be valuable to help people recollect what occurred during a meeting. The information should be distributed to stakeholders. Guidelines on recording activities are presented below.

Guidelines for recording activities

▸ Ask a person who does not have an active role in the planning process to record the meeting.

▸ Records should be factual. The record taker should record what each person actually said, rather than their interpretation.

▶ Records should be distributed to the people involved in the planning process.

▶ Update the person's case notes to indicate when the plan was developed, the outcomes and the follow-up date.

▶ Prepare the initial care plan based on the meeting notes and have it checked by your supervisor.

▶ Make sure names and medications are spelt correctly, and dates and other details are accurate.

▶ Make sure that the person and any other key service providers also have a copy of the developed plan.

Prepare reports

It is likely that you will be required to prepare a variety of reports as part of your role. Reporting will differ depending on the situation, the information being shared and your organisation's policies and procedures. The reporting could be informal or a formal document. At times during service delivery implementation or planning, you will observe something or an incident will occur that requires specific reporting, following organisational policies and procedures. Below are some ways of reporting.

Verbal reporting

In some situations it may be advisable, or adequate, to report verbally. This may be a telephone call or a face-to-face report. Verbal reporting is quick and can share information instantly if an immediate response is required.

Written reporting

Written reports include file notes on a person's case file, progress reports to stakeholders, incident reports after an incident has occurred, workplace health and safety or hazard reports from various workplaces or service delivery plans.

Prepare other documentation

Many of the documents, reports and records completed by workers are considered legal records of the support provided to individuals and how the organisation manages WHS and infection control. Most government-funded organisations undergo regular audits, where records are examined to ensure work is carried out to the appropriate standard. Furthermore, different types of information may need to be documented at different times, and several people may enter information on a single record.

The protocols for recording information should be detailed in organisational policies and procedures, and confidentiality and record management must meet legislative requirements. Seek advice from your manager if you have questions about recording information.

Be objective and record facts

Professional standards require that reports and documents use objective language based on fact and observation. Objective language describes what has been observed or heard, while subjective language may be based on feelings, emotions or opinions. Objectivity is important for accuracy and accountability and ensures individuals are described in ways unaffected by judgments, stereotypes, assumptions or opinion. You also need to ensure the language suits the audience. Each part of the community sector often has its own jargon – special words or expressions used by staff. To ensure clarity, avoid abbreviations, acronyms and jargon.

Objective or factual information is compared with subjective information below.

Objective versus subjective language
Objective: Mrs Smith stated, 'I am feeling depressed'. Subjective: Mrs Smith seemed depressed.
Objective: Alex rose quickly, slammed the door and raised his voice. Subjective: Alex acted aggressively.
Objective: Mark uses heroin regularly. Subjective: Mark is a drug addict.
Objective: Mr Thompson requires full physical assistance with meal preparation. Subjective: Mr Thompson is unable to cook for himself at home.

Meet record-keeping requirements

When completing workplace documentation, there are other points to consider, including meeting timing requirements, maintaining confidentiality, ensuring the accurate recording of the person's details, using appropriate forms, amending documents and obtaining authorisation. These considerations are discussed below.

Meet timing requirements

The nature of a report or document, along with the expectations of the organisation, determines the time lines and protocols for its completion. Reports such as funding submissions or statistical reports to government have time frames that are set externally. Internal documentation is dictated by urgency, organisational policy and the end use of the information.

Your organisation will have standard operating procedures for completing individual's documents on intake, when developing care plans, when providing care, when consulting with others and when reporting incidents and accidents.

Maintain confidentiality

Case notes, programming and incident reports often include interactions that involve events with other people. Confidentiality of person's receiving services and others must be maintained when writing notes or reports recorded in another person's file or records.

Record details accurately

Spelling is another critical aspect of recording information. Spelling a person's name incorrectly may have a number of unintended consequences. Their data may be confused with another person's data, leading to serious privacy breaches, confusion or duplication of records. Incorrect spelling of medical terms can cause confusion; for example, the treatments for and effects of hyperthyroidism and hypothyroidism are quite different.

Read information back to the person and/or their advocate to confirm its accuracy. While this may take extra time, clarifying information helps prevent mistakes that may take considerable time and effort to rectify later.

Control changes

Completed documents generally must not be changed. Errors or alterations should be identified in an additional note or new record, clearly explaining the reason for the change. Do not use correcting fluid to change a written note or record. Computer-based records may not allow changes to saved information.

Use forms

Use the appropriate form or report template, as this helps other workers identify the required information. Follow protocols about using organisational stationery. Make sure you have completed all sections and entries make sense, and that writing is legible and comprehensible.

Obtain authorisation

Records should be signed and dated by the person completing them. Computer-based records may require a log-in to access records that identify the author. For reports, show drafts to another authorised person for feedback; some organisations have a requirement that any outgoing reports are signed off by a manager.

Follow organisational reporting requirements

Reporting and documentation requirements in aged care, mental health, disability, home and community care and other community services settings are extensive. Maintaining accurate information enables workers to respond to a person's needs and provide effective and quality services. Information lacking accuracy or currency about a person's status, or the issues affecting them, may mean incorrect care or disjointed services are provided.

Documents also provide evidence of the actions compliant with industry standards in the event of an incident, accident or other adverse effect. Another compelling reason for complying with organisational reporting and recording requirements is to demonstrate accountability to, and compliance with, the requirements of service users, funding bodies, government and other stakeholders.

Using a strengths-based approach requires you to ensure that reporting documentation reflects the strengths and capacities of the person. This means that planning documentation and service delivery documentation, like case notes, refer to the person's strengths and what can be achieved rather than their deficits (what they cannot do).

Collect information

Your current or future workplace will have policies that dictate how information is gathered, who receives information about a person's progress, how the information is stored and who may access the information. These policies are designed to help organisations meet their requirements under different legislation, regulations or industry standards, including privacy laws, freedom of information legislation, regulations and codes of practice, and aged care, mental health or disability services standards and principles.

Examples of workplace reports and documentation that collect information relevant to aged care, disability services, mental health, home and community care, or other community services needs include those related to person care and health and safety. Below are some general examples of reports that workers may be required to complete.

Personal information

A personal information form is completed the first time a person uses a service. The basic information about the person may include:

▶ first, middle and last names

▶ address

▶ telephone number

▶ date of birth

▶ Medicare number

▶ emergency contact details

▶ details of medical conditions, allergies and medication.

Health assessments

Initial health assessments are used to identify physical, psychological, emotional and cultural needs. Support workers may not be directly responsible for completing these forms with a person, but this information can be used to develop an understanding of the progress of the person's general condition or provide an insight into changes in their health condition. Health assessments can include:

▶ health assessment questionnaires

▶ cognitive function questionnaires

▶ intake interviews.

Individualised plans

Individualised plans always include:

▶ the person's goals

▶ activities and action to implement the plan

▶ personnel responsible

▶ resources required

▶ measurable outcomes.

Case documentation

Case documentation can include:

▶ medical records and test results

▶ progress notes

▶ completed questionnaires

▶ completed assessment tools

▶ service delivery plans

▶ records of client feedback.

Medical reports help assess a person's needs, as they provide a wide range of information about a person's current physical and mental health, and future prognoses. This information may also be used to assess a person's eligibility for other support services.

WHS reports

All support workers have health and safety responsibilities. Communicating with others about risks is part of these responsibilities. If you witness a workplace accident involving a person receiving services or another person, you may be required to fill out an accident report form. Recording near misses or incidents also helps make improvements to workplace safety to minimise hazards or risks.

Service data

Service data includes hours spent on each activity with each person in each program area, and is usually entered directly into an electronic database, as required by the funding body, government department or organisation's board. Data is often collected daily and submitted quarterly.

Organisational reports

Organisational reports include annual reports, strategic plans and business plans. These are generally produced on an annual basis.

Project and program reports require regular progress reports at intervals throughout project or program delivery. Evaluation reports are provided following the completion of a project.

Human resources

A time sheet records the hours you have worked and, in some cases, the people you have seen and details such as kilometres driven. An accurate time sheet determines your pay and may also be used for invoicing a person receiving services or funding bodies for hours of service provided.

Coordinators and managers need to keep track of staff training and development, including formal and informal training.

When staff performance is assessed, a record of the outcomes and a plan for development or improvement are completed. Some organisations may ask you to complete a self-appraisal to say how you think you are performing and how you could develop and improve in your role.

Store documentation

Records must be stored in the correct place so they can be easily located and referred to when required. Within a person's file, each type of record or document will be stored in the same place. For example, you might find that personal information is always at the front, progress notes next, assessments behind that and payment records at the back. For electronic files, particular information is recorded in a specific form or field. Many community agencies use electronic systems that allow users to input all personal details, referrals, assessments and case notes directly to a database.

Other types of documents such as incident reports, safety checklists and time sheets may also be stored electronically. These systems may be password-protected, which limits access to authorised staff only.

Types of documentation to be stored

Privacy laws demand that an agency has valid reasons for collecting, storing and disseminating information about individuals. There are also various guidelines on file retention times. There may also be times when additional information is required to meet new standards. For example, when privacy legislation was introduced, community service providers had to get both existing and new people requiring services to sign 'consent to disclose information' forms. If they did not do this, it would be illegal for them to share this information with other agencies.

Below are examples of different types of information and storage protocols.

Information about legislation and standards

Information about legislation and standards is stored as a reference for obligations of the organisation and workers, and to ensure currency and accessibility of information about legislation and standards.

In some organisations, this information is stored within policy documents. It may also be displayed visually (for example, on posters) to increase accessibility.

Information about other agencies

General information about other agencies is stored as a reference for the organisation and workers, and to ensure currency and accessibility of information about other services so it can be disseminated or accessed as required.

This information may be filed or stored electronically. It is not confidential, so it does not have to be locked or password protected.

Organisational policies and procedures

Organisational policies and procedures are stored as a reference for obligations of the organisation and workers, and to ensure information about policies and procedures is accessible and up to date.

This information may be in hard copy and provided to staff. In some organisations, policies and procedures are only available electronically, to ensure the most recent records are used.

Individual files and information

Individual files and information are stored so a plan can be developed and implemented to meet individual needs, and to meet duty-of-care and other legal requirements.

This information may be stored in a locked filing cabinet or password-protected database, or as electronic files with limited access.

Staff information

Staff information is stored so human resource functions (recruitment, induction, professional development, performance appraisal) can be implemented, and to meet duty-of-care and WHS obligations.

This information may be stored in a locked filing cabinet or password-protected database, or as electronic files with limited access.

Security of information

You must always follow organisational procedures for updating and storing information to ensure it is current and can be readily retrieved by authorised personnel. Information should always be kept in safe and secure areas. It is common to store hard copy files in a lockable cabinet with files stored alphabetically by surname.

Example

Record planning activities and decisions made, and prepare reports and other documentation

Wendy has just completed a care plan with Sunil. In the plan she records Sunil's goals and the strategies and resources needed to achieve these goals. Wendy places the plan in Sunil's case file which is kept in a locked filing cabinet.

Care plan			
Name: Sunil Singh		**Date of birth:** 13/05/1945	
Gender: Male		**Conditions:** Osteoporosis	
Goals	**Strategy**	**People responsible**	**Resources needed**
To prevent falls To increase mobility To improve safety	Fosamax once weekly on an empty stomach.	Personal care assistant	Medication cup Fosamax Tablets Water
	Encourage Sunil to wear non-slip shoes.	Sunil Personal care assistants Nursing staff	Appropriate footwear
	Encourage Sunil to use a walking frame.	Sunil Personal care assistants Nursing staff	Walking frame
Created: 13/04/2016			
Created by: Wendy Smith, Registered nurse			
Review date: 13/05/2016			
Or earlier if resident experiences a fall or a near fall			

Practice task 20

1. List some of the types of information that might be collected for inclusion in reports and other documentation.

2. Explain why objective language is important in reporting documents.

Click to complete Practice task 20

5B Maintain currency of documentation by making appropriate updates

Recording and documenting work is an ongoing task. Documentation needs to be current, in other words it should not be allowed to get out of date. You should also complete documentation as the work is done to prevent errors or omissions. It could be required at any time by other workers, your supervisor, government agencies or for legal proceedings. The general rule is that records of past work are stored and maintained, even if they no longer appear relevant, or have been superseded by more recent information. Your workplace will have procedures and guidelines about how and when documentation is to be maintained.

Maintain currency of documentation

When facilitating individualised plans, you should ensure all documentation is up to date and readily accessible by all parties involved in the person's care. If you forget to complete paperwork, there may be significant consequences later on in terms of accountability and reliability, particularly if financial documents are involved or there are external reporting requirements to be met. Maintaining documentation also helps when you need to follow up a particular issue. Here are some tips for maintaining documentation.

Tips for maintaining documentation

▶ Ensure the currency of a person's personal details, such as a change of address or a new advocate, and regularly check if any have changed.

▶ Make sure assessment forms are completed correctly, signed by the relevant health professional and filed in the person's personal file.

▶ File all documents, such as meeting minutes or complaint forms, in the relevant files.

▶ Check that feedback questionnaires have been read and followed up.

▶ Check that environmental assessment checklists have been completed accurately and filed in the correct file.

▶ Ensure care plans are amended after observation or a formal review.

▶ Hold regular meetings to ensure staff are completing progress reports and communication notes in the person's communication book.

▶ Check with staff to ensure they are completing incident reports when necessary.

▶ Record all training sessions with staff concerning implementing care plans.

Make appropriate updates

Updates to service delivery plans or other documentation can be necessary if there is a change in the person's circumstances that lead to a change in plans. Updates may also be necessary if an incident occurs or a hazard is observed. You will need to update the person's case file as progress is made or if there are any concerns raised. For example, you may need to update personal details if the person moves.

Example

Maintain currency of documentation by making appropriate updates

Jenna is a support worker for an in-home support service. When she visits a person in their home, she signs a sheet to indicate that care has been provided as per the care plan. If there is information that other workers, or the person or their carer may need to know, this is noted in the communication book in the person's home. Urgent information is reported by phone to her supervisor. Once a week, Jenna is paid for an additional hour to go into the office and enter information about the care she has provided into each person's computer record. It is expected that information about each person is never more than one week out of date.

Practice task 21

Read the case study, then complete the task that follows.

Case study

Roy has worked with Carl to develop an individualised plan. Roy has placed the plan in Carl's case file and given copies to stakeholders. After two months, Roy observes that Carl has made significant progress towards meeting his goals, including moving to a permanent home.

1. How should Roy update Carl's file?

2. Describe the tasks Roy should do to maintain current documentation.

Click to complete Practice task 21

5C Incorporate review findings into continuous improvement processes

You, and your organisation, should regularly review service delivery implementation, and incorporate review findings into a continuous improvement process. Continuous improvement is a process of constantly reviewing and implementing changes to ensure that service delivery implementation is improved and meets best practice standards.

Continuous improvement processes

Your organisation's continuous improvement should be a systematic and ongoing effort to improve the quality of care and services. The focus of this process should be the individuals receiving care. Improvement should be achieved through a series of planned steps based on monitoring and evaluation of current practice and progress being made.

Continuous improvement should:

▶ consider the needs of individuals receiving services and involve them, where possible, in improvement activities

▶ involve, where possible, other key stakeholders like family members, staff, carers, advocates and others

▶ be part of a review system to assess how well service delivery implementation is working

▶ be measured in terms of results by observable outcomes

▶ be a focus of your organisation and should be contributed to and understood by all staff.

Example

Incorporate review findings into continuous improvement processes

An example of a continuous improvement plan as part of the process can be seen below.

Date	Issues identified	Related policies/ procedures	Planned action	Planned completion date
12.4.15	Feedback from family members/carers of individuals receiving services indicates dissatisfaction with levels of involvement in planning processes	Family inclusive practice policy. Family feedback form.	Train staff in family-inclusive practice. Update planning documentation to include family input	March 2016

Practice task 22

1. Define continuous improvement.

2. Explain four things a continuous improvement process should do.

Click to complete Practice task 22

Summary

1. Follow your organisation's requirements to record all planning activities and prepare reports and documentation.

2. It is important to maintain currency of documentation by making appropriate updates.

3. You should incorporate the findings of reviews into a continuous improvement process to ensure good service delivery implementation.

Learning checkpoint 5
Complete reporting requirements

This learning checkpoint allows you to review your skills and knowledge in completing reporting requirements.

Part A

1. When keeping workplace records, what basic requirements should be adhered to?

2. Describe the factors that should be considered when recording activities.

3. Explain how continuous improvement should occur after a review.

Part B

Read the case study, then answer the questions that follow.

> ### Case study
>
> Greg has met with Jude to discuss the progress Jude is making with regards to her service delivery plan. Jude tells Greg that she is struggling with one goal, to walk 30 minutes every day, as the change in seasons means it has been raining regularly. Up until recently, however, Jude has been managing to walk at least 30 minutes a day and is showing commitment to her physical health. Greg and Jude decide that a better option for this time of year is for Jude to use the exercise bike sitting in the shed.

1. In order to maintain the currency of Jude's records, what should Greg do?

2. What strengths has Jude demonstrated? How could Greg document this?